Daniel L. Mengedoth, DDS, Ltd.
2585 23rd Ave. S., Suite C
Fargo, ND 58103

www.drdanmengedoth.com

701.356.1280

Adult Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Birth Date:

_____

Previous Dentist

Previous Dentist's Name,Address, City, State, Zipcode, Telephone

_____

How long were you a patient there?

_____

Frequency of dental care:

- ◯ Regular (every 3-6 months)
- ◯ Periodic (every 7-12 months)
- ◯ Infrequent (more than every 12 months)
- ◯ Emergency (for pain/problem management)

Please describe your daily oral health routine.

_____

Please describe any dental concerns.

_____

Please tell us why you have chosen our office for your dental care.

_____

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Adult Dental History Form (Continued)

Please check all that apply:

- [ ] Have dental pain or discomfort
- [ ] Have had upsetting dental experience
- [ ] Have nervous feelings about receiving dental treatment
- [ ] Have sensitivity to temperature, pressure, or food/drink
- [ ] Have unpleasant taste or odor in my mouth
- [ ] Have gums which hurt or bleed when brushing or flossing
- [ ] Have been told I have gum disease
- [ ] Have been treated for gum disease
- [ ] Have active dental disease
- [ ] Have family history of gum disease
- [ ] Have lost permanent (adult) teeth other than wisdom teeth
- [ ] Have desire to learn how to control my dental disease and retain my teeth
- [ ] Have noticed loose teeth or changes in my bite
- [ ] Have food catching between my teeth
- [ ] Have had my bite adjusted
- [ ] Have worn a bite splint or night guard
- [ ] Have experienced a serious injury to my mouth or head
- [ ] Have had orthodontic treatment (i.e. braces or retainers)
- [ ] Have had oral surgery (i.e. wisdom teeth removed)
- [ ] Have been told that I require premedication with antibiotics prior to dental treatment
- [ ] Have concerns about the finances required to achieve excellent oral health

Please explain any checked responses above:

Response Date: