

Daniel H. Markham, D.M.D.  
Dental History Form

Patient Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Why did you come to the dentist today?

Please check if you have any of the following dental problems:

- |                    |     |                              |
|--------------------|-----|------------------------------|
| Abscess in Mouth   | ___ | Where? _____                 |
| Bad Breath         | ___ | Do you know the cause? _____ |
| Bleeding Gums      | ___ | Where, when? _____           |
| Clenching/Grinding | ___ | Describe: _____              |
| Cold Sores         | ___ | Where, how often? _____      |
| Difficulty Chewing | ___ | Describe: _____              |
| Dry Mouth          | ___ | Describe: _____              |
| Infection in Gums  | ___ | Where? _____                 |
| Loose teeth        | ___ | Where? _____                 |
| Missing Teeth      | ___ | Where? _____                 |
| Pain in Jaw Joint  | ___ | Describe: _____              |
| Sensitive teeth    | ___ | Hot, Cold, Sweets? _____     |
| Tobacco Products   | ___ | Type, frequency? _____       |
| Stained teeth      | ___ | Where? _____                 |

Would you like to discuss implants with Dr. Markham? Yes: \_\_\_ No: \_\_\_

Would you like to discuss Bleaching or Whitening? Yes: \_\_\_ No: \_\_\_

\_\_\_\_\_  
Patient Signature ( If minor, Parent or Guardian) Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_