DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken teeth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Snoring

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum Treatments

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is your level of fear you have about your dental visits?

1 2 3 4 5 6 7 8 9 10

Please share the following dates:

Your last cleaning _____

Your last dental exam _____

Your last complete x-rays _____

Name of previous Dentist

_____

City: _____ State _____

Phone: _____

Why did you leave your previous dentist?

_____

_____

_____

If you could change your smile, you would:

- ☐ Make teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace old or metal fillings
- ☐ Repair chipped teeth
- ☐ Repair missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Would you like to know about options available to you for maximizing your comfort during your visit?

Check all that apply: ☐ Nitrous Oxide ☐ Educational Materials ☐ Blanket/Pillow

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

Print Patient Name: _____ Date: _____