DENTAL HISTORY

Name: _____

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

☐ Sensitivity (hot, cold, sweet)
☐ Tooth pain or discomfort when chewing
☐ Headaches, earaches, neck pain
☐ Jaw joint pain
☐ Teeth or fillings breaking
☐ Grinding or clenching teeth
☐ Bleeding, swollen or irritated gums
☐ Loose, tipped or shifting teeth
☐ Bad breath or bad taste in your mouth

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

☐ Dentures
☐ Partial denture
☐ Braces
☐ Peridontal (gum) treatments

Please share the following dates:

☐ Your last cleaning ____/____
☐ Your last oral cancer screening ____/____
☐ Your last complete X-rays ____/____

Name of Previous Dentist:

_____
City _____ State _____
Phone Number _____

Why did you leave your previous dentist?

_____
_____

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

_____
_____

Are you interested in whiter teeth?

☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

☐ Yes How Much? _____
How Long? _____
☐ No

If you could change your smile, you would:

☐ Make it brighter
☐ Make it straighter
☐ Close Spaces
☐ Replace black metal fillings with tooth-colored fillings
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Have a smile makeover

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 your rate your current dental health?

1 2 3 4 5 6 7 8 9 10

EMERGENCY CONTACT NOT RESIDING WITH YOU:

Name _____
Relationship _____
Phone Number _____