Dental History

Patient's Name: _____ Today's Date: _____

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 Dentures
- ○ Braces
- ○ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ___/___
Your last oral cancer screening ___/___
Your last complete X-rays ___/___

Why did you leave your previous dentist?

_____

Do you smoke or use chewing tobacco?

How much? For how long?

If I could change my smile, I would:

- ○ Make them brighter
- ○ Make them straighter
- ○ Close spaces
- ○ Replace black metal fillings with natural, 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 the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would rate your current dental health?
1 2 3 4 5 6 7 8 9 10

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?

_____

_____