DENTAL HISTORY

Patient Name	Date

Please check any of the following that apply to you.

Sensitivity (Hot, Cold, Sweets) ☐
Where? UR, LR, UL, LL
Headaches, earaches, neck pain ☐
Jaw Joint Pain ☐
Teeth or fillings breaking/chipping ☐
Grinding or clenching teeth ☐
Bleeding, swollen, or irritated gums ☐
Loose, tipped or shifted teeth ☐
Bad breath ☐

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

Dentures ☐
Partial Dentures ☐
Braces ☐
Gum Treatment ☐
Oral Surgery ☐

Do you floss daily? YES NO
Do you brush daily? YES NO

Please share the following dates:

Your last cleaning ___/___
Your last oral cancer screening ___/___
Your last complete set of X-Rays ___/___

What is your previous Dentist's name?

_____

Do you smoke or use chewing tobacco?

YES NO

How much? _____
For how long? _____

If I could change my smile, I would:

Make them whiter ☐
Make them straighter ☐
Close spaces ☐
Replace black metal fillings with tooth colored restorations ☐
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 smile 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

Why did you leave your previous dentist?

_____

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

_____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe:

_____