DENTAL HISTORY

Name:_____ Date:_____

Please list all ALLERGIES:

_____
_____
_____
_____
_____

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
- ☐ Snoring
- ☐ Teeth or fillings breaking
- ☐ Grinding and 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
- ☐ Periodontal (gum) treatments

Please share the following dates:

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

Name of Previous Dentist:

_____
_____

Phone Number:_____

Why did you leave your previous dentist?

_____
_____
_____
_____

Do you smoke or use chewing tobacco?
How much and for how long?

_____
_____

If you could change your smile, you would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace silver 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 you 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?

_____
_____
_____
_____