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
- ☐ Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning __ / __
- Your last oral cancer screening __ / __
- Your last dental X-rays __ / __

Name of Previous Dentist:

_____

City:_____ State: _____

Phone Number:(___)_____

Have you had any unusual reactions or complications to medications or anesthesia?

☐ *Yes* ☐ *No* ***If yes, please explain below:***

_____

_____

_____

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 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

Why did you leave your previous dentist?

_____

_____

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

_____

_____

EMERGENCY CONTACT NOT RESIDING WITH YOU:

Name: _____

Relationship: _____

Phone No.: _____

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