DENTAL HISTORY

Patient Name: ______ Last ______ First ______ MI

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

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

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

- Dentures
- Partial dentures
- Braces/Orthodontic treatment
- Periodontal (gum) treatments

Please share the following dates

Your last cleaning: ______

Your last oral cancer screening: ______

Your last complete x-rays: ______

Previous Dental Office

Name: ______

City & State: ______

Phone Number: ______

Do you smoke or use chewing tobacco?

Yes No

If you could change your smile, you 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

On a scale from 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 future smile & dental health?

Response Date: