DENTAL HISTORY

Please check any of the following that apply to you:

-Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL
-Headaches, ear aches, neck or jaw joint pain ☐
-Mouth ulcers or cold sores ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose teeth ☐
-Bad breath ☐

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

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Gum treatments ☐

Please share the following dates:

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

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐
How much? For how long?

If I could change my smile, I would: ☐
-Make my teeth whiter ☐
-Make my teeth straighter ☐
-Close spaces ☐
-Replace 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 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 today? _____