PATIENT: _____ DATE: _____

DENTAL HISTORY

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
  Where: UR LR UL LL
- ☐ Sore teeth
- ☐ Avoid brushing any part of your mouth
- ☐ Teeth or fillings breaking
- ☐ Lost any teeth
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath
- ☐ Unpleasant taste or odor in your mouth
- ☐ Burning sensation in mouth
- ☐ Mouth ulcers or cold sores
- ☐ Bleeding, swollen or irritated gums
- ☐ Difficulty swallowing
- ☐ Headaches, earaches, neck or jaw joint pain
- ☐ Grinding or clenching teeth
- ☐ Jaw clicking or popping
- ☐ Difficulty opening mouth widely
- ☐ Stiff neck muscles
- ☐ Unhappy with the appearance of your teeth
- ☐ Unfavorable dental experience
- ☐ Dental Fear
- ☐ Problems with effectiveness or reactions to dental anesthetic

Please share the following dates (mm/yy):

- Your last cleaning: ____/____
- Your last oral cancer screening: ____/____
- Your last complete x-ray's: ____/____

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

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

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, 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

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? _____

_____

How often do you have your teeth cleaned? ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 1 yr. or longer

Are you interested in having regular cleanings? ☐ Yes ☐ No

Is saving your teeth important to you? ☐ Yes ☐ No

Previous Dentist Information:

Name: _____

City: _____ State: _____ Zip _____ Phone # _____

Reason for leaving your previous dentist? _____

_____

☐ *The information I have given is true and accurate to the best of my knowledge.*

_____ _____

Signature **Date**