Dental History

First Name _____ Last Name _____

Why are you changing dentist? _____

How long since the last visit to a dentist?

Name of previous dentist?

How did you find us? _____

Who may we thank for referring you? _____

Reason for today's visit

- ☐ Check Up
- ☐ Cleaning
- ☐ Pain
- ☐ Other: _____

Have you ever had a bad experience at the dentist?

- ☐ No
- ☐ Yes

Have you had any complications following treatment?

- ☐ No
- ☐ Yes

Have you had unfavorable reaction to dental anesthetic?

- ☐ No
- ☐ Yes

Does dental treatment make you nervous?

- ☐ No
- ☐ Yes

Are your teeth sensitive to cold, hot?

- ☐ No
- ☐ Yes

Do your gums bleed when you brush or floss?

- ☐ No
- ☐ Yes

Do you grind your teeth?

- ☐ No
- ☐ Yes

Are you aware of sores or irritated areas in the mouth?

- ☐ No
- ☐ Yes

Have you ever been treated for Periodontal Disease?

- ☐ No
- ☐ Yes

How often do you brush?

How often do you floss? _____

Do you like your smile?

- ☐ No
- ☐ Yes

If you could change your smile, what would you like to change?

- ☐ Change the color of my teeth
- ☐ Close spaces or restore worn and broken teeth
- ☐ Change the shape of my teeth
- ☐ Change the position or alignment of my teeth
- ☐ Other: _____

I am interested in:

- ☐ Teeth whitening
- ☐ Cosmetic evaluation
- ☐ Replacement of missing teeth
- ☐ Straight teeth
- ☐ Sedation
- ☐ White fillings
- ☐ Home care
- ☐ Breath control
- ☐ Other: _____

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about:

Signature Date