Dental History

PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT APPLY TO YOU

- ☐ Bad breath
- ☐ Bleeding, swollen or irritated gums
- ☐ Canker sores
- ☐ Cold sores
- ☐ Grinding or clenching
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint popping, clicking, or pain
- ☐ Loose, tipped, or shifted teeth
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Snoring, sleep apnea
- ☐ Teeth or fillings breaking
- ☐ Toothache

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ Dental Implants
- ☐ Night guard / Bite splint

How many sugary or acidic drinks do you have each day? (soda, diet soda, coffee with sugar, juice, energy drinks…) _____

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

_____

_____

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

_____

_____

IF I COULD CHANGE YOUR SMILE, I WOULD:

- ☐ Make them whiter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace dark metal fillings with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Have a more youthful smile

ON A SCALE OF 1 -10 WITH 10 BEING THE HIGHEST:

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

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

PLEASE SHARE THE FOLLOWING DATES:

Your last dental cleaning ___/___

Your last oral cancer screening ___/___

Your last complete x-ray exam ___/___

NAME OF PREVIOUS DENTIST _____

CITY/STATE _____

PHONE NUMBER _____