

## DENTAL HISTORY

Patient Name	Date
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**Please check any of the following that apply to you.**

- Sensitivity (Hot, Cold, Sweets)   
Where? UR, LR, UL, LL
- Headaches, earaches, neck pain
- Jaw Joint Pain
- Teeth or fillings breaking/chipping
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped or shifted teeth
- Bad breath

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

- Dentures
- Partial Dentures
- Braces
- Gum Treatment
- Oral Surgery

**Do you floss daily?** YES NO

**Do you brush daily?** YES NO

**Please share the following dates:**

Your last cleaning \_\_\_\_\_/\_\_\_\_/\_\_\_\_

Your last oral cancer screening \_\_\_\_\_/\_\_\_\_/\_\_\_\_

Your last complete set of X-Rays \_\_\_\_\_/\_\_\_\_/\_\_\_\_

**What is your previous Dentist's name?**

\_\_\_\_\_

**Do you smoke or use chewing tobacco?**

YES NO

How much? \_\_\_\_\_

For how long? \_\_\_\_\_

**If I could change my smile, I would:**

- Make them whiter
- Make them straighter
- Close spaces
- Replace black 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 smile 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?**

\_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?**

If yes, please describe:

\_\_\_\_\_