DENTAL HISTORY

Name:_____

Please check any of the following problems that apply to you.

	Yes	No
Sensitivity (hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
Teeth or filling breaking	☐	☐
Grinding or clenching teeth	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Loose, tipped or shifting teeth	☐	☐
Do you have or have you had any of the following?		
Dentures	☐	☐
Partial dentures	☐	☐
Braces	☐	☐
Periodontal (gum) treatments	☐	☐
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use tobacco?	☐	☐
How much?_____For how long? _____		
If I could change my smile, I would:		
Make it whiter	☐	☐
Make it 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	☐	☐

Please share the following dates

Your last cleaning _____

Your last oral cancer screening_____

Your last X-Rays _____

Name of Previous Dentist_____ City _____ State_____

Phone Number _____

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

Where do you want your dental health to be?

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 future smile and dental health?_____

_____

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

_____

Are there any comments you care to make? _____