Dental Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Please check any of the following that apply to you.

☐ Sensitivity to: Hot, Cold, Sweet
☐ Chipped / Broken Teeth
☐ Crooked or Tipped Teeth
☐ Loose Teeth
☐ Missing or Spaces Between Teeth
☐ Catch Food Between Teeth
☐ Dry Mouth or Constantly Thirsty
☐ Smoke or Use Chewing Tobacco

☐ Bleeding, Swollen or Irritated Gums
☐ Dissatisfied With Appearance of My Teeth
☐ Frequent Headaches
☐ Jaw Joint Pain
☐ Grinding or Clenching Teeth
☐ Uncomfortable or Uneven When I Bite My Teeth Together
☐ Clicking or Popping of Jaw
☐ Difficulty Opening or Chewing

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

☐ Dentures or Partial
☐ Braces or Clear Braces
☐ Periodontal Disease or Gum Treatments
☐ Fixed Bridge
☐ Dental Implants
☐ Crowns

☐ Veneers
☐ Jaw Surgery
☐ Root Canals
☐ Sleep Apnea
☐ C-PAP Machine or Oral Sleep Appliance
☐ Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

☐ Make My Teeth Whiter
☐ Make My Teeth Straighter
☐ Close Spaces or Gaps That Bother Me
☐ Replace Dark Metal Fillings With Tooth Colored Fillings
☐ Fix My Teeth So I’m Not Embarrassed When I Smile

☐ Repair Chipped Teeth
☐ Replace Missing Teeth
☐ Replace Old Crowns That Look Dark or Don’t Match
☐ Have a Smile Makeover
☐ Stop My Jaw From Hurting or Clicking

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

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No
Tell me how I can straighten my teeth in 6 months instead of 2 years and if I’m a candidate? ☐ Yes ☐ No
Have you ever been sedated for dental treatment? ☐ Yes ☐ No
Are you interested in sedation options? ☐ Yes ☐ No
Have you ever whitened your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following?

Date of last cleaning? __/___ Date of last oral cancer screening? __/___ Date of last complete x-rays? __/___

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

Why did you leave your previous dentist? ____________________________________________