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 Partials
- 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? _____