DENTAL HISTORY FORM

Patient's Name (Please print)	**Date**

Please check any of the following problems that apply to you

Sensitivity (hot, cold, sweet)	☐
Tooth pain or discomfort when chewing	☐
Headaches, earaches, neck pain	☐
Jaw joint pain	☐
Broken teeth or broken fillings	☐
Grinding or clenching teeth	☐
Bleeding, swollen or irritated gums	☐
Loose, tipped or shifting teeth	☐
Bad Breath or bad taste in your mouth	☐
Dentures	☐
Partial dentures	☐
Braces	☐
Periodontal (gum) treatments	☐

If I could change my smile, I would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No
Do you smoke or use chewing tobacco? Yes No
If so, how much do you smoke/chew and how long have you smoked/chewed?_____

One 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
How would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10

Please share the following dates:

Your last cleaning _____
Your last oral cancer screening _____
Your last complete x-rays _____
Name of previous dentist _____
City_____ State _____

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?

_____