

DENTAL HISTORY

What is the reason for your visit today? _____

Previous Dentists name and address _____

Date of your last dental visit _____ Last dental cleaning _____ Last X-rays _____

What was done at your last dental visit? _____

How often do you have your teeth cleaned? _____ How often do you brush? _____

How often do you Floss? _____ Other dental aids? (electric tooth brush, etc.) _____

On a scale from 1 – 10 (10 being the highest) what priority do you give your teeth? _____

Are your teeth sensitive to hot or cold? Sweets?	Yes No	Have you ever had:	
Are your teeth sensitive to biting or chewing?	Yes No	Orthodontics (braces)?	Yes No
Does food get caught between your teeth?	Yes No	Periodontal treatment?	Yes No
Does gum disease run in your family?	Yes No	Oral surgery?	Yes No
Do your gums bleed or cause pain?	Yes No	Teeth extracted?	Yes No
Do you have areas of receded gums?	Yes No	Night guard or bite splint?	Yes No
Do you smoke or chew tobacco?	Yes No	An injury to the mouth or head?	Yes No
Do you bite fingernails, pen tops, straws etc?	Yes No	If so, please explain _____	
Do you drink coffee, colas, tea, red wine?	Yes No	Do you like the color of your teeth?	Yes No
Do you clench or grind your teeth?	Yes No	Have you whitened your teeth?	Yes No
Do you have tired jaws in the morning? Evening?	Yes No	Would you like whiter teeth?	Yes No
Do you have popping, clicking or pain of the jaw?	Yes No	Do you like the length or shape of your teeth?	Yes No
Do you have any missing teeth?	Yes No	Would you like your teeth straightened?	Yes No
If yes, would you like the teeth replaced?	Yes No	Do you have any crowns that are not as attractive as you would like?	Yes No
Do you have any unattractive metal fillings that you would like replaced with white fillings?	Yes No		

Have you ever had an upsetting dental experience? _____

What is your greatest concern about dental treatment? (i.e. cost, time, pain) _____

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

So that we may better serve your dental needs, were there any concerns that you felt your previous dentist did not address? _____