

## DENTAL HISTORY

**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
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

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

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

**Please share the following dates:**

Your last cleaning \_\_\_/\_\_\_

Your last oral cancer screening \_\_\_/\_\_\_

Your last complete X-Rays \_\_\_/\_\_\_

**Name of Previous Dentist:**

\_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

\_\_\_\_\_

**Do you smoke or use chewing tobacco?  
How much? For how long?**

\_\_\_\_\_

**If you could change your smile, you 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

**On a scale of 1 – 10, with 10 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

**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?**

\_\_\_\_\_