DENTAL HISTORY

PATIENT NAME ______________________________

WELCOME! So that we may provide you with the best possible care please complete this dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________________

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Date of Last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ____________

What was done at your last dental visit? ______________________________

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Previous Dentist's Name ______________________________

Are you satisfied with your past dentistry? ____________ Why or why not? ______________________________

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How often do you have dental examinations? ______________________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other dental aids do you use? (Oral B Braun, toothpick, etc.) ______________________________

How would you rate your dental health (please check): ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any dental problems now? ❑ Yes ❑ No

If yes, please describe: ______________________________

Are you satisfied with your teeth's appearance? Yes No

Are there any old fillings or dental work that you don't liike looking at? Yes No

Would you like whiter teeth? Yes No

Do you like your smile? Yes No

If you could change anything about your smile, what would that be?

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When evaluating my smile, it's most important:

❑ What I See ❑ What Others See

Do you smoke/chew tobacco? Yes No

Do your gums bleed or hurt? Yes No

Are your gums shrinking away from your teeth? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? ______________________________

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? ______________________________

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Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

Do you like the way your teeth come together? Yes No

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Are you concerned about mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Would you like to keep all your teeth all of your life? Yes No

On a scale of 1-10 (10 being the highest) what priority do you give your teeth? 1 2 3 4 5 6 7 8 9 10

Is there anything else about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe: ______________________________

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