Dental History

Y N

Are your teeth sensitive to?

_____ _____ Heat
_____ _____ Cold
_____ _____ Sweets
_____ _____ Biting Pressure

_____ _____ Does food constantly get stuck between certain teeth in your mouth?

_____ _____ Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

_____ _____ Are you dissatisfied with your teeth in any way?

_____ _____ Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, ect.

_____ _____ Do any of your fillings show in your front teeth?

_____ _____ Do any of your fillings show when you smile?

Y N

_____ _____ If any of your mercury metal fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?

_____ _____ Have you ever had any teeth removed?

_____ _____ Do your gums bleed when brushing?

_____ _____ Do you avoid any part of your mouth when brushing?

_____ _____ Have you been instructed regarding proper oral hygiene?

_____ _____ Do you have an upleasant taste or odor in your mouth?

_____ _____ Do you frequently snack on sweets or chew gum?

_____ _____ Do you have a concern about fear or discomfort?

When was your last dental appointment?_____

How long has it been since you have had a full series of x-rays?_____

What has prompted you to seek dental care at this time?_____