



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?

- Fillings
- Crowns
- Braces
- Extractions
- Implants
- Periodontal (gum) treatments or surgery
- Partial Dentures
- Dentures

Please share the following dates (estimate if needed):

Your last cleaning ____/____

Your last oral cancer screening ____/____

Your last complete X-rays ____/____

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 from 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?

Name of Previous Dentist:

City: _____

State: _____

Phone Number: _____