



DENTAL HISTORY

Patient Name: _____

Please check any of the following problems that currently apply to you

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing or pressure sensitivity
- 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
- Night Guard
- CPAP
- TAP Appliance

Please share the following dates:

Your last cleaning ____/____

Your last oral cancer screening ____/____

Your last complete x-rays ____/____

Would you like us to request your records from your previous dentist? _____

Do you smoke or use chewing tobacco? _____

How much? For how long? _____

Do you have, or do you have a family history of:

- Oral or esophageal cancer
- Gum disease
- Tooth Loss/Dentures
- Sleep Apnea
- Fever Blisters
- Lichen Planus

If you could change your smile, you would:

- Make teeth brighter/whiter
- Decrease gummy smile
- Make teeth straighter
- Close spaces
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match

On a scale of 1 -10, with 10 being highest:
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

Name of Previous Dentist: _____

City/State: _____

Phone No: _____