DENTAL HISTORY

Patient Name: _____

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

- ☐ Sensitivity (hzot, 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? _____

Name of Previous Dentist:

_____

City/State: _____

Phone No: _____

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, with10 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☐