DENTAL HISTORY

Please check any of the following that apply to you:

- € Sensitivity (hot, cold, sweet) Location _____
- € Headaches, earaches, neck or jaw joint pain
- € Mouth ulcers or cold sores
- € Teeth or fillings breaking
- € Grinding or clenching teeth
- € Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following

- € Dentures _____
- € Partial Dentures _____
- € Braces _____
- € Periodontal Gum Treatments _____

If you could whiten your teeth for a cost anyone could afford, would you consider it?____

Do you smoke or use chewing tobacco? _____

How much? _____ How long? _____

If I could change my smile, I would:

- € Make my teeth whiter
- Replace metal fillings with tooth colored restorations
- Make my teeth straighter
- € Replace missing teeth
- € Replace old crowns that don't match
- € Have a smile makeover
- € Close spaces
- € Replace chipped teeth
- € Nothing, I am happy with my smile

On a scale of 1 – 10, with 10 being the highest rating: Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where would you like it to be?:

1 2 3 4 5 6 7 8 9 10

Please share the following dates:

Your last cleaning _____ Your last complete X-Rays _____

Your last oral cancer screening _____

Name of Previous Dentist _____
CITY STATE PHONE NUMBER

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health? _____

_____

What is your expectation of me? _____

_____

(Please continue on other side.)