Dental Health History

Patient Name_____Birth Date_____
Reason For Today's Visit_____Date of Last dental care_____
Former Dentist_____Date of the Last X-rays_____

Check (**X**) if you have problems with any of the following

- ❏ Bad Breath
- ❏ Bleeding gums
- ❏ Clicking or popping jaw
- ❏ Food collection between teeth
- ❏ Grinding teeth
- ❏ Loose teeth
- ❏ Broken Fillings
- ❏ Periodontal treatment
- ❏ Sensitivity to cold
- ❏ Sensitivity to hot
- ❏ Sensitivity to sweets
- ❏ Sensitivity when biting
- ❏ Sores or growth in your mouth

How often do you floss?_____ How often do you brush?_____

Please check if the following applies to you.
Do you have or had any of the following?

- ❏ Dentures
- ❏ Partial dentures
- ❏ Braces
- ❏ Periodontal (gum) treatments

Please answer following questions:
If you could whiten your teeth for a cost anyone could afford, would you do it? yes no
Do you smoke or chewing tobacco? yes no How much?_____How long?_____
If I could change my smile, I would:
Make it whiter yes no Make it straighter yes no Close spaces yes no
Replace black metal fillings with tooth colored restorations yes no
Repair chipped teeth yes no
Replace missing teeth yes no
Replace old crowns that don't match yes no
Have a smile makeover yes no
What is the most important to you about your future smile and dental health?_____

What is the most important to you about your dental visit today?_____