Dental History(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Dental History

What is the most important thing to you about your dental visittoday?

Dental History

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

Dental History

On a scale of 1-10, with 10 being the highest rating: How important is your dental health to you?

Dental History

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

Dental History

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

Sensitivity (hot, cold, sweet)	Yes	No
tooth pain or discomfort when chewing	Yes	No
Headaches, earaches, neck pain	Yes	No
Jaw joint pain	Yes	No
Teeth orfillings breaking	Yes	No
Grinding or clenching teeth	Yes	No
Bleeding, swollen or irritated gums	Yes	No
Loose, tipped or shifting teeth	Yes	No
Bad breath or bad taste in your mouth	Yes	No
Snoring	Yes	No

Do you have or have you had any of the following? If yes, please tell us what year?

Dentures	Yes	No
Partial dentures	Yes	No
Braces	Yes	No
Gum treatment	Yes	No
implants	Yes	No
Sleep study	Yes	No
Currently using CPAP	Yes	No

Do you smoke or use chewing tobacco	Yes	No
Vape?	Yes	No
How much?		Comment
For how long?		Comment

If I could change my smile, I would:

Make them brighter	Yes	No
Make them straighter	Yes	No
Close spaces	Yes	No
Repair chipped teeth	Yes	No
Replace missing teeth	Yes	No
Replace old crowns that don't match	Yes	No
Replace black metal fillings	Yes	No
Tooth colored fillings	Yes	No

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Signature of Patient, Parent or Guardian:

X

Date:___________