Dental History

Name of Previous Dentist _____ **Location** _____

Why did you leave your previous dentist? _____

Please share the following dates:

Last dental exam _____ /_____ Last Dental X-rays _____ /_____

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

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

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐Color ☐Bite ☐Chipped Teeth ☐Spaces ☐Crowding ☐Smile Makeover ☐Missing Teeth ☐Whiter Teeth

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

_____

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

_____

1. Do your gums bleed while brushing or flossing? ☐Yes ☐No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐Yes ☐No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐Yes ☐No
4. Do you feel pain to any of your teeth? If yes, please explain ☐Yes ☐No
5. Do you have any sores or lumps in or near your mouth? ☐Yes ☐No
6. Have you had any head, neck or jaw injuries? ☐Yes ☐No
7. Do you clench or grind your teeth? ☐Yes ☐No
8. Have you ever had any prolonged bleeding after extractions? ☐Yes ☐No
9. Have you had any orthodontic treatment? ☐Yes ☐No
10. Do you wear dentures or partials? ☐Yes ☐No
11. Have you ever been told that you need to take an antibiotic for dental work? ☐Yes ☐No
12. Do you have or have you ever had Oral Cancer? ☐Yes ☐No
13. Do you bite your lips or cheeks frequently? ☐Yes ☐No
14. Do you currently use or previously used tobacco or vape products? ☐Yes ☐No

    How Much: How Long _____

Have you ever experienced any of the following:

15. Clicking of your jaw ☐Yes ☐No
16. Pain (jaw joint, ear, side of face) ☐Yes ☐No
17. Difficulty in opening or closing ☐Yes ☐No
18. Difficulty in chewing ☐Yes ☐No
19. Day-time drowsiness, sleep apnea, or snoring ☐Yes ☐No
20. Dry Mouth ☐Yes ☐No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentists to release any information including my diagnosis and any records to facilitate in my or my child's dental care and/or receive reimbursement for any and all services provided

Patient Name_____Patient Signature _____ Date _____