DENTAL HISTORY

Name: **Date:** _____

_____ **Date Updated:** _____

Previous Dentist Why did you leave?	When was the last time you saw a dentist?	Date of last professional prophy (cleaning)

	CIRCLE
I am concerned with the **appearance** of my teeth or my smile.	Y or N
I am concerned about the **whiteness**/lack of whiteness of one or more of my teeth.	Y or N
I would like to learn more about tooth **whitening options.**	Y or N
There are some **chips or stains** on my teeth that concern me	Y or N
I am **missing** one or more of my teeth	Y or N
I am concerned with mouth **herpes**	Y or N
I am concerned with bleeding / puffy **gums**	Y or N
I have some **loose** teeth	Y or N
I have noticed **halitosis** (bad breath)	Y or N
I am interested in learning more about **aesthetic** (cosmetic) dentistry	Y or N
I am **nervous** at the dentist	Y or N
I would like to learn more about **laughing gas** or sedation while at the dentist	Y or N
Saving my teeth is important to me	Y or N
I **clench / grind** my teeth	Y or N

	CIRCLE
I am concerned about the **shape or angle** of one or more of my teeth	Y or N
In social situations, I am sometimes **embarrassed** by my teeth or my smile	Y or N
There are some things about my **upper front** teeth that I would like to change	Y or N
There are some things about my **lower front** teeth that I would like to change	Y or N
I have old fillings or **previous dental treatment** that is no longer satisfactory to me	Y or N
I have some areas of **sensitivity** with my teeth	Y or N
I would like to plan for good oral health and a healthy smile for my **retirement**	Y or N
I am interested in learning more about tooth **replacement**	Y or N
I would like to be able to **chew** all of my favorite foods	Y or N
I sometimes feel as if there is a coating on the surface of my **tongue**	Y or N
I **brush or scrape** my tongue	Y or N

I get **headaches/migraines** (how often) _____

Please rank your overall oral health and/or your smile from 1 (worst) to 10 (best)_____

What are some challenges you may be having with your oral health and/or your smile?_____

Which kind of toothbrush do you use?
_____Hard _____Medium _____Soft _____Electric _____Waterpik
How often do you brush your teeth?_____
What type of toothpaste do you use?_____
How often do you floss your teeth?_____

Have you tried any whitening products.....Yes No

Would you be interested in placing a protective coating or sealant on your teeth to prevent decay? .....Yes No

Have you ever had braces.....Yes No

Have you received care from any other dental specialist(s) .....Yes No

Please list any tooth problems, questions, or concerns:	If you are experiencing any sensitivity please indicate which tooth / teeth.	Is there anything we can do to improve on your previous dental experiences?

Signature:_____