Your Dental History

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So that we can give you a personalized experience, we ask that you share your previous dental experiences and your expectations for future visits.

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

- □ Sensitivity (hot, cold, sweet)
- □ Tooth pain or discomfort when chewing
- □ Headaches, earaches, neck pain
- □ Jaw joint pain
- □ Teeth or fillings breaking
- □ Grinding or Clenching Teeth
- □ Bleeding, swollen or irritated gums
- □ Loose, tipped or shifting teeth
- □ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- □ Dentures
- □ Partial Dentures
- □ Braces
- □ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning ___/___/___
Your last oral cancer screening ___/___/___
Your last complete X-rays ___/___/___

Name of previous Dentist:

_____
City: _____
State: _____
Phone Number: _____
Why did you leave your previous dentist?

_____

_____

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

_____

Name _____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could change your smile, you would:

- □ Make them brighter
- □ Make them straighter
- □ Close spaces
- □ Replace black metal fillings with natural, tooth-colored fillings
- □ Repair chipped teeth
- □ Replace missing teeth
- □ Replace old crowns that don't match
- □ Have a smile makeover

On a scale of 1-10, with 10 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

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?

_____

_____