Dental history

Reason for seeking dental care at this time _____

Former dentist _____ City/state _____

Date of last dental visit _____

Reason? _____ Date of last X-rays _____

How often do you: Brush _____ times per _____ Floss _____ times per _____

How do you feel about dental treatment?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ Very anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

- ☐ Aching or sensitive teeth _____
- ☐ Broken filling _____
- ☐ Areas of food traps _____
- ☐ Unfavorable dental experience _____
- ☐ Sensitive or bleeding gums _____
- ☐ Loose teeth _____
- ☐ Difficulty opening wide _____
- ☐ Growths or lesions in your mouth _____
- ☐ Broken or missing teeth _____
- ☐ Bad breath _____
- ☐ Clicking or popping jaw _____
- ☐ Cold sores _____
- ☐ Grinding or clenching _____
- ☐ Swollen glands _____
- ☐ Jaw pain or tiredness _____
- ☐ Dry mouth _____
- ☐ Swelling or lumps in mouth _____
- ☐ Gum infection _____
- ☐ Orthodontic treatment _____
- ☐ Other _____

If you could change your smile, what would you change?

- ☐ Remove unsightly fillings
- ☐ Straighten teeth
- ☐ Change shape of teeth
- ☐ Close gaps in teeth
- ☐ Replace missing teeth
- ☐ Whitening
- ☐ Make teeth same color
- ☐ Other _____