Patient Name **Date of Birth** _____

_____
FIRST LAST

Previous Dentist: _____

City: _____ **State:** _____

Phone: _____

☐ **Male** ☐ **Female**

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
- ☐ 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

Comment: _____

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

Comment: _____

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal gum treatment

Comment: _____

Please share the following dates:

Your last cleaning was _____ago

Your last oral cancer screening was _____ago

Your last x-rays were taken _____ago

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

On a scale of 1 – 10, with 10 the best 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 dental visit today?

_____

_____

Do you smoke or use chewing tobacco? Yes or No

How Much? _____

How Long? _____

Why did you leave your previous dentist?

_____

_____

_____

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

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN'S SIGNATURE _____ **DATE**_____

DENTIST'S SIGNATURE _____ **DATE**_____

ANESTHETIC

DENTAL HISTORY

MEDICAL ALERT