

### Dental History

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Date \_\_\_\_\_

1. Why did you leave your last dental office? \_\_\_\_\_
2. What did you like most about your last dental office? \_\_\_\_\_
3. What did you like least about your last dental office? \_\_\_\_\_
4. How do you feel about your teeth and mouth? \_\_\_\_\_
5. When was your last dental appointment? \_\_\_\_\_  
What did you have done? \_\_\_\_\_
6. How long since your last *thorough* examination with *full mouth xrays*? \_\_\_\_\_
7. Please tell us who made your dental appointment today? \_\_\_\_\_
8. If someone besides yourself made your appointment should we contact that person with your treatment plan, if so what is the best # to contact them? \_\_\_\_\_
9. What do you expect from your consult today? \_\_\_\_\_
10. Describe your philosophy of dental care. (eg thorough and preventative, only worry if it hurts) \_\_\_\_\_
11. Are your teeth sensitive to:
 

heat?.....	yes	no
cold?.....	yes	no
sweets?.....	yes	no
biting pressure?.....	yes	no
12. Have your wisdom teeth been removed?..... yes no
13. Which toothpaste do you use? \_\_\_\_\_
14. If you use mouthwash, which one and how often? \_\_\_\_\_

**Primary Concerns:**

- |                            |               |                                |
|----------------------------|---------------|--------------------------------|
| Whiter Teeth               | Bleeding Gums | Tooth Loss                     |
| Straighter Teeth           | Snoring       | Fear of Pain                   |
| Removal of Silver Fillings | Sleep Apnea   | Teeth Not Supporting Upper Lip |
| Grinding Teeth             | Bad Breath    | Unhappy with Facial Profile    |
| Sore Facial Muscles        | Flossing      | Prevention/Education           |
| Jaw Pain/Popping Jaw       | Wisdom Teeth  | Pain in Teeth                  |
| Cavities                   | Younger Smile | More Attractive Smile          |
| Veneers                    | Bonding       | Orthodontics/Braces            |
| Cosmetic Consult           | Dentures      | Gum Disease                    |
| Enlarged Jaw Muscles       | Headaches     | TMJ                            |
| Botox                      | Implants      | Lumineers/Snap on Smile        |

**Other Concerns:** \_\_\_\_\_