

PATIENT DENTAL HISTORY

PATIENT NAME: _____

Are you having any pain? _____

Do you have any sensitivity to hot, cold, or sweets? _____

Does dental treatment make you nervous? _____

If yes, what concerns you most about having dental treatment? _____

Which of the following concern you about dental treatment?

_____ Time "I am very busy."

_____ Fear "I am afraid of one or more things about dental treatment."

_____ Money "I may need or want to make payments."

Have you experienced any of the following problems?

Bleeding Gums _____

Soreness in the jaw _____

Snoring _____

Trouble chewing _____

Bad Breath _____

Grinding of teeth _____

Frequent Headaches _____

Loose teeth _____

On a scale of 1-5 with 5 being the highest:

How important is your dental health to you? _____

Where would you rate your dental health? _____

Where would you like your dental health to be? _____

How would you rate your smile? _____ Embarrassing _____ Decent _____ Okay _____ Perfect

When was the last time you had your teeth cleaned? _____

When was the last time you had an Oral Cancer Screening? _____

Is the whiteness of your teeth important to you? _____

Do you use tobacco in any form? How much? _____

Do you routinely drink coffee, tea, or red wine? _____

If I could change my smile, I would:

_____ Make them whiter

_____ Have less gum showing

_____ Repair chipped teeth

_____ Change silver fillings into tooth colored

_____ Replace any old crowns or caps that don't match

_____ Replace missing teeth

_____ Close spaces

_____ Make them straighter

What is your daily routine of cleaning your teeth? How much time do you spend each day doing that?

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?
