

# D E N T A L ♦ H I S T O R Y

Previous Dentist & Location \_\_\_\_\_ Last Exam Date \_\_\_\_\_ Last Cleaning Date \_\_\_\_\_

Reason for Leaving? (optional) \_\_\_\_\_

Current Dental Needs or Concerns \_\_\_\_\_

Reason for Visit Today? \_\_\_\_\_

Check any of the following concerns or desires:

Existing Discomfort    Replace Old Silver Fillings    Gum Disease    Mouth Odor    Whitening

Prevent Decay    Smile Makeover    Straighten    Emergency Treatment

Are you having any PAIN in your teeth?

Where? \_\_\_\_\_ For how long? \_\_\_\_\_ How severe? \_\_\_\_\_

Have you noticed any broken fillings, broken teeth, or cracks in your teeth?

Where? \_\_\_\_\_

Have you noticed bleeding gums when you brush or floss?

Do you have any teeth that are sensitive to hot, cold, sweets, or air?

Where? \_\_\_\_\_ For how long? \_\_\_\_\_ How severe? \_\_\_\_\_

Have you noticed any bumps, sores or lumps in or near your mouth?    Yes    No

Have you ever experienced any head, neck or jaw injuries?    Yes    No

Clicking/Popping    Difficulty chewing    Pain (joint, ear or side of face)    Frequent Headache

Clenching/Grinding    Jaw locking open/closed    Biting cheeks or lips

Difficulty opening/closing

Have you had Orthodontics, Braces, or Invisalign?    Yes    No   Approximate Date of Completion \_\_\_\_\_

Orthodontist's Name \_\_\_\_\_ Location \_\_\_\_\_

Have you ever Whitened or Bleached your teeth?    Yes    No   Products used \_\_\_\_\_

Please darken the level of fear you have about your dental visits:

low fear ← ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ → high fear

Have you ever had a bad experience at a dental office? What happened? \_\_\_\_\_

Would you like to know more about any of the following relaxing amenities?

Nitrous oxide/laughing gas    Sedative medications    Music    TV/Video    Blankets/Pillows

What would you like to change about your smile?

Tooth Shape    Spacing    Color    Size    Straightness    Bite    Breath    Overall Smile

When discussing your treatment plan, do you prefer to receive?

Big picture summary    What's next only?    Itemized, detailed explanation

I certify that I have read and understand the above information to the best of my knowledge and have answered the questions accurately. I authorize the dentist to release any information or records necessary to obtain payment from my insurance company, and authorize benefits to be paid directly to my dental office. I understand that I am financially responsible for any balances that I incur for services rendered.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_