Patient Name ______________________

Birthdate ______________________

Teeth Whitening *Replacement of missing teeth* *Cosmetic evaluation*
Straight teeth *White fillings* *Home care* *Breath control*

DENTAL HISTORY

Reason for today's visit ______________________

Former Dentist ______________________ Phone # ______________ City/State ______________

Date of last dental visit ______________________ Date of last dental X-Rays ______________________

Date of last dental cleaning ______________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use? ☐ Electric Toothbrush ☐ Manual Toothbrush ☐ Soft ☐ Medium ☐ Hard
☐ Toothpick ☐ Fluoride Rinse ☐ Other______________

Have you received any formal oral hygiene instruction? Y / N How long ago? ______________

Do you like your smile? Y / N Rate your smile from 1 - 10 ________

How do you feel about the appearance of your teeth? ______________________

What do you wish could be changed? ______________________

Are you interested in straightening your teeth (orthodontic treatment)? Y / N Have you had braces before? Y / N

Please circle YES or NO to indicate if you have had or currently have any of the following:

Gag easily	Y N	Discomfort with HOT foods/liquids	Y N	Pain in face, cheeks, jaw joint	Y N
Avoid brushing because of pain	Y N	Clench or Grind your teeth	Y N	Chew on only one side of the mouth	Y N
Notice slow-healing sores in the mouth	Y N	Temporamandibular jaw disorder	Y N	Gums feel swollen or tender	Y N
Your Jaw makes noise OR gets stuck	Y N	Take fluoride supplements	Y N	Discomfort with sweet or sour food	Y N
Earaches or pain in front of your ear	Y N	Difficulty chewing	Y N	Discomfort when chewing	Y N
Habitually chew gum	Y N	Gums bleed when flossing	Y N	Had trauma to the jaw	Y N
Gums bleed easily	Y N	Discomfort with COLD food or liquid	Y N		

If you could change your smile, what would you like to change? *(please circle)*

The color of my teeth *Close spaces or restore worn and broke teeth*
The shape of my teeth *The position or alignment of my teeth*
Other ______________________

I'm interested in *(please circle)*

Teeth Whitening *Replacement of missing teeth* *Cosmetic evaluation*
Straight teeth *White fillings* *Breath control*

A serious injury to the mouth or head Y N Please describe, including the cause ______________

Food collection between teeth Y N Please indicate location ______________________

Oral Surgery (Extractions) Y N

Endodontic Treatment (Root Canals) Y N

Periodontal Treatment (Gums- Deep Cleaning) Y N If yes, please indicate:

Osseous Surgery Date ______________

Tissue Gingival Grafts Date ______________

Tissue Management (Scaling, Curetage) Date ______________

Do you feel nervous about having dental treatment? Y N

Have you ever had an upsetting dental experience? Y N

Do you have any other concerns about your mouth? Y N

If yes to any of the above, please describe ______________________

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