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 Headaches

☐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⇦①②③④⑤⑥⑦⑧⑨⑩⇨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_____