

# DENTAL HISTORY

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

1. Is keeping your teeth important to you? (Y) (N)

If yes, why? \_\_\_\_\_

2. On a scale of 1-10, 10 being the best, where would you rate your smile and oral health? \_\_\_\_\_

3. Is the brightness of your smile important to you? (Y) (N)

4. Have you experienced any of the following problems:

Bleeding gums	(Y) (N)	Sensitivity to Hot & Cold	(Y) (N)
Bad breath or sour taste in mouth	(Y) (N)	Snoring	(Y) (N)
Food catching between your teeth	(Y) (N)	Soreness in jaw	(Y) (N)
Grinding of teeth	(Y) (N)	Pain/ soreness around eyes, ears or face	(Y) (N)
Clicking or Popping in jaw	(Y) (N)	Stiff neck muscles	(Y) (N)
Dry Mouth	(Y) (N)	Headaches/Migraines	(Y) (N)

5. Does having dental treatment make you afraid or nervous? (Y) (N) If yes, what specific things bother you?

\_\_\_\_\_

6. If you could change anything about your smile which of the following would you want? (please circle)

Whiter	Straighter	Close spaces/gaps
Replace missing teeth	Less gums showing	Replace old crowns
Excess teeth showing	Replace old silver fillings	Remove stains/spots on teeth
Reshape/resize teeth	Replace chipped teeth	

7. Fill in this question for us please.

Where do you see yourself and your overall health and/ or your smile in the next 5-10 years?

\_\_\_\_\_

**Please circle the following which are important to you when making your dental health decision.**

Convenience	Appearance	Relationship with the Dental Team
Finances	Time	Quality of care
Health	Fear of Anxiety	Detailed explanation of treatment
Comfort	Technology	