# Dental History

**What would you like to accomplish today?** _____
What prompted you to seek dental care at this time?_____
Have you been asked to take an antibiotic before dental treatment? ☐ Yes ☐ No

**Please check if you have ever had problems with any of the following:**

| | | | |
|---|---|---|---|
| ☐ Sensitivity to cold | ☐ Jaw/ear pain | ☐ Bleeding Gums | ☐ Food sticks between teeth |
| ☐ Sensitivity to hot | ☐ Grinding/clenching teeth | ☐ Periodontal treatment | ☐ Mouth sores/growths |
| ☐ Sensitivity when biting | ☐ Clicking or popping jaw | ☐ Loose teeth/broken fillings | ☐ Bad Breath/Taste |
| ☐ Sensitivity to sweets | ☐ Worn/chipped teeth | ☐ Dark teeth | ☐ Hard to floss |

## Home Care Evaluation

How often do you brush?_____ Toothbrush: ☐ Electric ☐ Regular ☐ Soft ☐ Medium ☐ Hard
How often do you floss?_____ Any other homecare devices that you use?_____
Is it difficult for you to brush or floss any areas of your mouth? ☐ Yes ☐ No
If yes, please describe:_____
Do your gums bleed when brushing or flossing? ☐ Yes ☐ No
Do you have dry mouth? ☐ Yes ☐ No
Do you want to learn to control dental disease & keep your teeth? ☐ Yes ☐ No
Have you ever been instructed in the prevention of decay? ☐ Yes ☐ No
Have you been instructed in caring for the health or your gums? ☐ Yes ☐ No
Do you feel like keeping your teeth healthy has been a losing battle? ☐ Yes ☐ No
If yes, why?_____
Do you have any concerns about getting your mouth in excellent health? ☐ Yes ☐ No
If yes, what concerns you?_____
Do you snack between meals on sweets, gum or soda pop? ☐ Yes ☐ No
Do you chew on both sides of your mouth? ☐ Yes ☐ No ☐ Unsure

## Smile Evaluation

How do you feel about the appearance of your teeth? _____
Do you like the way your smile looks? ☐ Yes ☐ No
If no, what dissatisfies you?_____
Do you sometimes hesitate to smile? ☐ Yes ☐ No
Are your teeth white enough? ☐ Yes ☐ No
Are there old fillings or dental work that look bad to you? ☐ Yes ☐ No
Do you like the shape of your teeth? ☐ Yes ☐ No
Are your teeth straight enough? ☐ Yes ☐ No
Do you have spaces between your teeth that you don't like? ☐ Yes ☐ No
Has cost prevented you from enhancing your smile in the past? ☐ Yes ☐ No

## Other History

Are you anxious about receiving dental treatment? ☐ Yes ☐ No
If yes, what do you dislike? _____
Has fear of discomfort kept you from regular dental visits in the past? ☐ Yes ☐ No
What else would you like us to know about your past dental experiences? _____
Have you ever had a reaction to a dental product or procedure? ☐ Yes ☐ No
If yes, please describe:_____

Previous Dentist:_____
Name City/State Phone
Date of Last visit:_____ Date of Last X-rays:_____
Month/Year Month/Year