

Patient's Name _____

Dental History

Name of Previous Dentist _____ Phone _____

Address _____

Was the same dental insurance used? Yes / No

Date of last dental exam _____

Date of last x-rays _____ Circle Type of X-rays: Full Set / Check-up films (4 x-rays) / Panorex

Date of last dental cleaning _____ Circle Type of cleaning: Routine / Scaling and Root Planing

Date of last dental visit and treatment received _____

Dental Condition: (circle all that apply)

Tooth Pain	Facial/Jaw Pain	Sensitivity	Decay	Loose Teeth	Bleeding Gums
Braces	Swelling/Lump	Difficulty Chewing	Clenching	Grinding	Gum Disease

Dental concerns/desires _____

Rate your level of dental anxiety (0- none, 5-severe) **0 1 2 3 4 5**

What causes your dental anxiety? _____

Special care needed for dental treatment:

Nitrous Oxide (Laughing Gas)

Anxiety Medication

IV Sedation

Head needs to be elevated

Short appointments

Frequent Breaks

Personal Dental History

What prompted you to seek dental care at this time?

How healthy does your mouth feel?

Rate your dental health on a scale of 1-10 (1-poor, 10-excellent) **1 2 3 4 5 6 7 8 9 10**

What factors do you feel are responsible for the above score?

Share why or why not you are satisfied with your past dental care.

Describe your last unpleasant dental experience.

What are your long term goals for your teeth?

What do you wish or expect of me as your Dentist?

Smile Review

Are your front teeth straight and even in length? **Yes No Not Sure**

Are your front teeth all the same color? **Yes No Not Sure**

Are your teeth darker than you would like? **Yes No Not Sure**

Are any of your fillings a different color from your natural teeth? **Yes No Not Sure**

Do any unsightly restorations show in your back teeth when you smile broadly or laugh? **Yes No Not Sure**

Are the gums receding from the teeth? **Yes No Not Sure**

Are the gums swollen or puffy? **Yes No Not Sure**

If you could change your smile, what would you most like to change?