



DENTAL HISTORY

	YES	NO		YES	NO
Do you currently have :			If you could whiten your teeth for a cost anyone could afford, would you do it?	<input type="checkbox"/>	<input type="checkbox"/>
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke; use smokeless tobacco or E- Cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
			How much? For how long?		
-Headaches, ear aches, neck or jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>	If I could change my smile, I would:	<input type="checkbox"/>	<input type="checkbox"/>
-Mouth ulcers or cold sores	<input type="checkbox"/>	<input type="checkbox"/>	-Make my teeth whiter	<input type="checkbox"/>	<input type="checkbox"/>
-Broken Teeth or Broken Fillings	<input type="checkbox"/>	<input type="checkbox"/>	-Make my teeth straighter	<input type="checkbox"/>	<input type="checkbox"/>
-Grinding or clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>	-Close spaces	<input type="checkbox"/>	<input type="checkbox"/>
-Bleeding, swollen or irritated gums	<input type="checkbox"/>	<input type="checkbox"/>	-Replace metal fillings with tooth colored restorations	<input type="checkbox"/>	<input type="checkbox"/>
-Loose, tipped or shifting teeth	<input type="checkbox"/>	<input type="checkbox"/>	-Repair chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	-Replace missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?			-Replace old crowns that don't match	<input type="checkbox"/>	<input type="checkbox"/>
-Dentures	<input type="checkbox"/>	<input type="checkbox"/>	-Talk about my snoring	<input type="checkbox"/>	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>	<input type="checkbox"/>			
-Braces	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 – 10, with 10 being the highest rating:		
-Gum treatments	<input type="checkbox"/>	<input type="checkbox"/>	-How important is your dental health to you?		
-Snore or someone has told you that you snore?	<input type="checkbox"/>	<input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10		
- Do you play sports?	<input type="checkbox"/>	<input type="checkbox"/>			

Please share the following dates:

-Your last cleaning _____ / _____

-Your last oral cancer screening _____ / _____

-Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today? _____
