DENTAL HISTORY

Do you currently have :	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Broken Teeth or Broken Fillings	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐
-Snore or someone has told you that you snore?	☐	☐
- Do you play sports?	☐	☐

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke; use smokeless tobacco or E- Cigarettes? How much? For how long?	☐	☐
If I could change my smile, I would:	☐	☐
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Talk about my snoring	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

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? _____

Crosspoint Dentistry Where We Provide Lifetime, Comprehensive Customized Care

Name:_____ Date:_____