Dental History

____________________________ ____________________________ _______

First Name Last Name Date

		Yes	No
1.	ARE YOUR TEETH SENSITIVE TO:		
	Heat?	Yes	No
	Cold?	Yes	No
	Sweets?	Yes	No
	Biting Pressure?	Yes	No
2.	DOES FOOD CONSTANTLY GET STUCK BETWEEN CERTAIN TEETH IN YOUR MOUTH?	Yes	No
3.	DO YOU GET FRUSTRATED BECAUSE YOU ALWAYS HAVE SOMETHING TO BE TREATED OR REPAIRED WHEN YOU VISIT A DENTIST?	Yes	No
4.	ARE YOU DISSATISFIED WITH YOUR TEETH IN ANY WAY?	Yes	No
5.	ARE YOU DISSATISFIED WITH THE WAY YOUR TEETH LOOK? (COLOR, SHAPE, SPACES)	Yes	No
6.	DO YOU HAVE ANY FILLINGS THAT SHOW IN YOUR FRONT TEETH?	Yes	No
7.	DO ANY OF YOUR FILLINGS SHOW WHEN YOU SMILE?	Yes	No
8.	IF ANY OF YOUR MERCURY AMALGAM FILINGS NEED REPLACEMENT, WOULD YOU PREFER TO HAVE A MORE NATURAL TOOTH-COLORED RESTORATION INSTEAD?	Yes	No
9.	HAVE YOU EVER HAD ANY TEETH REMOVED	Yes	No
10.	HOW LONG HAVE THESE TEETH BEEN MISSING?	__________________	
11.	DO YOUR GUMS BLEED WHEN BRUSHING?	Yes	No
12.	DO YOU EVER AVOID ANY PART OF THE MOUTH WHILE BRUSHING?	Yes	No
13.	HAVE YOU BEEN INSTRUCTED REGARDING PROPER HOME CARE?	Yes	No
14.	DO YOU HAVE AN UNPLEASANT TASTE OR ODOR IN YOUR MOUTH?	Yes	No
15.	DO YOU SMOKE?	Yes	No

16. DO YOU FREQUENTLY SNACK BETWEEN MEALS ON SWEETS OR CHEW GUMS? Yes No

17. HOW OFTEN DO YOU BRUSH YOUR TEETH? _______________

18. HOW OFTEN DO YOU FLOSS? _______________

19. DO YOU WANT TO LEARN TO CONTROL DENTAL DISEASE AND RETAIN YOUR TEETH? Yes No

20. HAS THE FEAR OF DISCOMFORT KEPT YOU FROM REGULAR DENTAL VISITS? Yes No

21. ARE YOU DEEPLY CONCERNED ABOUT THE FINANCES REQUIRED TO RETURN YOUR MOUTH TO EXCELLENT DENTAL HEALTH? Yes No

22. WHEN WAS YOUR LAST DENTAL APPOINTMENT? _______________

23. WHAT DID YOU HAVE DONE? _______________

24. HOW LONG SINCE YOUR LAST THOROUGH EXAMINATION WITH FULL MOUTH X-RAYS? _______________

25. WHAT PROMPTED YOU TO SEEK DENTAL CARE AT THIS TIME?

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SIGNATURE PATIENT __________________ DATE ____/___/____

SIGNATURE DOCTOR__________________ DATE ____/___/____

Remarks:

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