Dental History

Name *

First Name

Last Name

Email Address *

Phone Number *

How do you feel about dental treatment?

○ Relaxed ○ A little uneasy ○ Tense ○ Anxious ○ Very Anxious

Have you seen a dentist before?

○ Yes ○ No

If so, when was your last dental visit?

How would you rate your previous dental experience?

What are your dental concerns?

Have you avoided regular dental care?

○ Yes ○ No

If so, why have you avoided regular dental care?

Are you happy with the appearance of your teeth?

○ Yes ○ No

If not, why are you unhappy with the appearance of your teeth?

How often do you brush?

How often do you floss?

How often do you use other aids?

water flosser, gum picks, gum stimulator, etc.

Would you like your teeth to be whiter?

○ Yes ○ No

Would you like your teeth to be straighter?

○ Yes ○ No

Do you have, or have you ever had any of the following dental conditions? Please check all that apply. *

- ☐ Aching or sensitive teeth
- ☐ Active decay of teeth or gums
- ☐ Areas of food traps
- ☐ Bad breath
- ☐ Broken filling
- ☐ Broken or missing teeth
- ☐ Cavities
- ☐ Clicking or popping jaw
- ☐ Cold sores
- ☐ Difficulty opening wide
- ☐ Dry mouth
- ☐ Aesthetic concerns with teeth
- ☐ Facial surgery
- ☐ Gag easily
- ☐ Growths or lesions in your mouth
- ☐ Gum infection / disease
- ☐ Gum treatments
- ☐ Jaw pain or tiredness
- ☐ Jaw clenching
- ☐ Loose teeth
- ☐ Night guard
- ☐ Oral surgery
- ☐ Orthodontic treatment
- ☐ Sensitive or bleeding gums
- ☐ Swelling or lumps in mouth
- ☐ Swollen glands
- ☐ Teeth grinding
- ☐ Unfavorable dental experience
- ☐ None of the above

Previous dentist or dental office

Name of previous dentist or dental office

City

Select a state / province

State / Province

To the best of my knowledge, the questions on this

my (or patient's) health. It is my responsibility to inform the dental office of any changes in status.

Signature *