DENTAL HISTORY-NEW PATIENT

Patients Name: _____

Please check the following:	**YES**	**NO**
-Sensitivity (hot, cold, sweet)	☐	☐
-Tooth pain or discomfort when chewing	☐	☐
-Tooth pain or discomfort	☐	☐
-Bad breath or bad taste in your mouth	☐	☐
-Headaches, earaches, neck aches or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Loose, tipped, or shifting teeth	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Snoring	☐	☐
Do you have or have you had any of the following?	☐	☐
-Dentures	☐	☐
-Implants	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ____/____

-Your last oral cancer screening ____/____

-Your last complete X-Rays ____/____

Why did you leave your previous dentist?

_____

_____

	YES	**NO**
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke, use chewing tobacco, or vape?	☐	☐

How much? _____

For how long? _____

If I could change my smile, I would:	**YES**	**NO**
-Make my teeth brighter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Have a smile makeover	☐	☐
-Replace metal fillings with natural tooth-colored fillings	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that do not match	☐	☐

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

What is the most important thing to you about the health of your mouth in the future?

_____

_____

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

_____

_____