Patient Dental History

Previous Dentist & Location _____

Date of Last Appt. _____

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. Are you dissatisfied with the way your teeth look?
   Yes No
   Example: color, shape, spaces, crowding

4. Do you have fillings that show in your front teeth?
   Yes No

5. Do you have any fillings that show when you smile?
   Yes No

6. Do you want to replace your mercury amalgam fillings with a more natural, tooth-colored restoration instead?
   Yes No

7. Have you ever had any teeth removed?
   Yes No

8. How long have these teeth been missing? _____

9. Do your gums bleed when brushing?
   Yes No

10. Has your former dentist/hygienist ever taught you how to brush your teeth?
    Yes No

11. Do you ever avoid any part of the mouth while brushing?
    Yes No Why? _____
    _____

12. Do you have an unpleasant taste or odor in your mouth?
    Yes No

13. Do you smoke or use smokeless tobacco?
    Yes No

14. Do you snack between meals on sweets or chew gum?
    Yes No

15. How often do you brush your teeth?
    _____

16. How often do you floss) _____
    (Please be honest, we can tell if you aren't)

17. Do you want to learn to control dental disease and retain your teeth?
    Yes No

18. Has fear of discomfort kept you from regular dental visits?
    Yes No

19. When was your last dental appointment? _____

20. What did you do? _____

21. How long since your last thorough examination with full mouth x-rays)
    _____

22. What prompted you to seek dental care at this time? _____