# Dental History

**Patient First name** *

**Patient Last Name** *

**Why you are changing dentist?**

- [ ] Change of residence
- [ ] Change of dental plan
- [ ] Your office is closer
- [ ] My dentist retired/closed
- [ ] Unhappy
- [ ] Too expensive
- [ ] You were recommended
- [ ] Other

**Please explain**

**How long since the last visit to dentist?** *

- [ ] 1 month
- [ ] 3 months
- [ ] 6 months
- [ ] 1 year
- [ ] 2 years
- [ ] 3 or more years
- [ ] I've never seen a dentist

**How did you find us?** *

- ( ) Other Patient
- ( ) Dental Office
- ( ) Yelp Google
- ( ) Internet
- ( ) Yellow Pages
- ( ) Mailer
- ( ) Work
- ( ) School
- ( ) Insurance Company
- ( ) Other

**Reason for the visit** *

- [ ] Check-up
- [ ] Cleaning
- [ ] Pain
- [ ] Other

**Please provide details**

**Have you ever had a bad experience at the dentist** *

- ○ No
- ○ Yes

**If yes please explain**

**Have you had any complications following dental treatment?** *

- ○ No
- ○ Yes

**If yes please explain**

**Have you had unfavorable reaction to dental anesthetic?** *

- ○ No
- ○ Yes

**If yes please explain**

**Does dental treatment make you nervous?** *

- ○ No
- ○ Yes, Slightly
- ○ Yes, Moderately
- ○ Yes, Extremely

**Are your teeth sensitive to cold, hot?** *

- ○ No
- ○ Yes

**Do your gums bleed when you brush or floss?** *

- ○ No
- ○ Yes

**Do you grind your teeth?** *

- ○ No
- ○ Yes

**Are you aware of sores or irritated areas in the mouth?** *

- ○ No
- ○ Yes

**Have you ever been treated for Periodontal Disease?** *

- ○ No
- ○ Yes

**How often do you brush?** *

- ○ Once a day
- ○ Twice a day

- ○ Three times a day
- ○ Every time I eat

**How often do you floss?** *

- ○ Never
- ○ Occasionally
- ○ Once a day
- ○ Twice a day
- ○ Three times a day
- ○ Every time I eat

**Do you like your smile?** *

- ○ No
- ○ Yes

**If you could change your smile, what would you like to change?**

- ☐ The color of my teeth
- ☐ Close spaces or restore worn and broken teeth
- ☐ The shape of my teeth
- ☐ The position or alignment of my teeth
- ☐ Other

**If Other please specify**

**I am interested in** *

- ☐ Teeth whitening
- ☐ Cosmetic evaluation
- ☐ Replacement of missing teeth
- ☐ Straight teeth
- ☐ Sedation
- ☐ White fillings
- ☐ Home care
- ☐ Breath control
- ☐ Other

**If Other please specify**

**To ensure your visit is a great experience, please share any questions or concerns you would like us to know about**

Continue