

DENTAL HISTORY FORM

Patient Full Name _____

Reason for today's visit

Former Dentist _____ **City/State** _____

Date of last dental visit _____ **Date of last dental X-Ray** _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following

- | | | | | | |
|-----------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Bad breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw pain or tiredness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding gums | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blisters on lips or mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loose teeth or broken filling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning sensation on tongue | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chew on one side of mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Orthodontic treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sores in your mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fingernail biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to cold | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Foreign objects | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to hot | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grinding teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to sweets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gums swollen or tender | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity when biting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sensitivity when chewing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

How often do you floss? _____

How often do you brush? _____

If the answer is "Yes" to any of these questions, you may be a good candidate for cosmetic dentistry.

- | | | |
|--|------------------------------|-----------------------------|
| Are you embarrassed about smiling in front of people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you ever put your hand up to cover your smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you dislike your smile in photographs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| When you look through magazines, do you envy the models' smiles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you wish your teeth were whiter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you think you show too much or too little of your teeth when you smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would you like to change the way your teeth or gums are shaped? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have gaps or spaces between your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have crooked or misaligned teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signature _____

Date _____