DENTAL HISTORY

Patient Name: _____ Date: _____

Date of Last Dental Visit: _____

What did you like the MOST about any dental office you have visited?

_____

What did you like the LEAST about any dental office you have visited?

_____

How did you hear about our office? (Please check one)

Valpak _____ Internet (website) _____ Newspaper article _____ Yellow Pages ____

Insurance _____ Walk In _____ Other _____

Patient referral (Care Enough to Share Card) _____

If a patient referral, please tell us who to thank for referring you _____

Do you have (or have you had) any of the following?

- Orthodontic treatment Yes ___ No ___
- If yes, do you still wear your retainer Yes ___ No ___
- Difficulty with opening or closing your jaw Yes ___ No ___
- Clicking or popping of your jaw Yes ___ No ___
- Night Guard Yes ___ No ___
- Bleeding when you brush your teeth Yes ___ No ___
- Red, swollen or tender gums Yes ___ No ___
- Persistent bad breath Yes ___ No ___
- Permanent tooth/teeth loose or separating Yes ___ No ___
- Changes in your bite Yes ___ No ___
- Any changes in the fit of your partial/denture Yes ___ No ___

What are you expecting to have done at your first visit?

_____

Have you ever been treated for gum disease? Yes ___ No ____ If yes, please tell us when, where, and by whom this was done: _____

Does dental treatment make you nervous? (Please check one) Yes ___ No ___ Moderately ___ Extremely ___

Do you like your smile? Yes ___ No ___

What would you like to change about your teeth? _____

Anything else we should know?

_____