# Dental History

What is your immediate dental concern? _____
Do you have dental pain now? _____
When was your last dental visit? _____
What was done at that appointment? _____
When was your last cleaning and exam? _____ Were x-rays taken? _____
Who was your previous dentist? _____City _____ Phone _____
What influenced you to change dentists? _____
Are any of your teeth sensitive to hot or cold? Yes No Biting or chewing pain? Yes No
Please check if you have or have ever had:

| | |
|---|---|
| Unfavorable dental experiences ..... | Difficulty opening your mouth widely ..... |
| Dental fears ..... | Stiff or sore head, neck & shoulder muscles |
| Preference for no dental anesthetic ..... | Do you wake up with tooth or jaw pain ..... |
| Tension headaches ..... | Clench or grind your teeth ..... |
| Jaw clicking or popping ..... | Bleeding gums ..... |
| Any oral appliances ..... | Any removable teeth ..... |
| Family history of diabetes ..... | Part of your mouth sensitive to temperature |
| Lumps or bumps on head or neck ..... | Dry mouth ..... |
| Do you have a sugar or soda pop habit ..... | Unpleasant taste or odor in your mouth ..... |
| Notice loose teeth or a change in your bite | Viral infection or cold sores ..... |
| Jaw problems (TMJ) ..... | Orthodontic treatment (braces) ..... |
| How often do you: Brush _____ Floss _____ | When? _____ |
| Parents who have lost teeth or | Breathe through your mouth while |
| had gum disease ..... | awake or asleep ..... |
| Problems with effectiveness of | Habitual chewing of hard substances |
| or bad reactions to dental anesthetic ..... | ie, ice, popcorn kernels ..... |

How important is it for you to keep your teeth for the rest of your life (circle one)

Not Important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile if you could? _____
_____

What is your biggest concern about having dental treatment? _____
_____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of its knowledge. However, all charges for services and collection costs for untimely payments are ultimately my responsibility.

Signature (Parent's if minor) _____ Date _____