DENTAL HISTORY

Patient's Name: _____

Date: _____

Please share the following dates:

Your last dental cleaning _____

Your last oral cancer exam _____

Is saving your teeth important to you? Yes or No

If yes why?_____

Does having dental treatment make you afraid or nervous? [Y] or [N] if yes, what specific things bother you?_____

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?

1 2 3 4 5 6 7 8 9 10

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures/Partial Dentures
- ☐ Implants
- ☐ Orthodontic (braces) treatment
- ☐ Periodontal (gum) treatments

If you could change anything about your smile which of the following would you want?

- ☐ Whiter
- ☐ Replace missing teeth
- ☐ Excess showing of teeth
- ☐ Reshape/resize my teeth
- ☐ Straighter
- ☐ Less gum showing
- ☐ Replace old plastic filling(s)
- ☐ Replace chipped teeth
- ☐ Close space or spaces
- ☐ Remove stains/spots on teeth
- ☐ Remove silver fillings

Please check the following which are important to you when making your dental health decision.

- ☐ Convenience
- ☐ Finances
- ☐ What insurance covers
- ☐ Appearance
- ☐ Time
- ☐ Health
- ☐ Comfort
- ☐ Relationship with Dental Team
- ☐ Quality of care
- ☐ Detailed treatment explanations
- ☐ Technology