

## 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?