DENTAL HISTORY

First Name: ________________ Middle Initial: ___ Last Name: __________________

Name of Your Former Dental Office: _____________________ Phone: (___) __________

Street Address: ______________________ City: ____________ State: ____ Zip: ____

When Was Your Last Dental Visit? _______ For: ______________________________

Do You Have Any Immediate Dental Concerns? ❒ Yes ❒ No If Yes: ______________
____
____

How Often Do You Brush Your Teeth Each Day? ______________________________

How Often Do You Floss, and/or Use Soft Picks? _____________________________

How Do You Feel About the Appearance of your Teeth? _________________________
____

Is There Anything You Would Like to Change About Your Smile? __________________
____
____

Would You Like to Know What Could Be Done to Improve the Appearance of Your Smile? ❒ Yes ❒ No

Are You Interested in Learning About Straightening Your Teeth? ❒ Yes ❒ No

Check If You Have Any of the Following:

❒ Hot Sensitivity ❒ Cold Sensitivity ❒ Sweet Sensitivity

❒ Bad Breath ❒ Bleeding Gums ❒ Periodontal Treatment

❒ Broken Fillings ❒ Loose Teeth ❒ Clenching/Grinding

❒ Food Collection ❒ Clicking/Popping Jaw ❒ Mouth Sores/Growths

❒ Other: ____

____
Signature Date