PATIENT NAME_____ DENTAL HISTORY

How long has it been since you have seen a dentist? _____

When was your last complete dental exam? _____

When did you last have full mouth x-rays taken? _____

Are you having any dental problems now? Please list: _____

Is your present dental health poor?	yes	no
If you wear dentures, are you unhappy with them?	yes	no
Are you apprehensive about dental treatment?	yes	no
Have you had "bad" dental experiences in the past?	yes	no
Have you had any periodontal (gum) treatment?	yes	no
Do your gums bleed, feel tender or irritated?	yes	no
Are your teeth sensitive to hot, cold, sweets, or pressure?	yes	no
Do you have headaches, earaches, or neck pains?	yes	no
Do you have loose, tipped, or shifting teeth?	yes	no
Have you ever worn braces on your teeth?	yes	no
Do you have discolored teeth that bother you?	yes	no
Are you unhappy with the appearance of your teeth?	yes	no
Are your teeth or fillings breaking?	yes	no
Would you like your smile to look better or different?	yes	no

If you could change one thing about your smile, what would it be? _____

Would you like us to help you learn proper methods of home care so you can stop dental problems in your mouth? yes no

How do you feel about your teeth? _____

Please rank the following in the order in which they would keep you from having dental treatment.

fear of pain #__ lack of concern #__

cost of treatment #__ missing work time #__

Name and Address of previous dentist: _____