CONFIDENTIAL

DENTAL HISTORY & PATIENT GOALS

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

DENTAL HISTORY

Dental Clinic _____ Dentist's Name _____

Street Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Date of Last Appt _____ Date of Last X-Rays _____

Why did you leave your previous dentist? _____

Check (✓) if you have or have had problems with any of the following:

Bad breath	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Tobacco use	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Chewing on foreign objects	☐ Yes	☐ No
Sores, blisters, growths on lips or mouth	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Thumb sucking	☐ Yes	☐ No
Biting cheeks or lips	☐ Yes	☐ No	Tongue thrusting	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Pain on brushing teeth	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No	Loose or broken teeth	☐ Yes	☐ No
Chewing	☐ Yes	☐ No	Loose or broken fillings	☐ Yes	☐ No
Swallowing	☐ Yes	☐ No	Food collection between the teeth	☐ Yes	☐ No
Talking	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Prominent gag reflex	☐ Yes	☐ No	Sensitivity to hot	☐ Yes	☐ No
Snoring	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Pyorrhea or trench mouth	☐ Yes	☐ No	Stained teeth	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No	Grinding or clenching teeth	☐ Yes	☐ No
Wisdom teeth extracted	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No
Bite problems	☐ Yes	☐ No	Jaw pain or fatigue	☐ Yes	☐ No
Missing teeth	☐ Yes	☐ No	Opening or closing jaw	☐ Yes	☐ No
Shifting position of teeth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No

How often do you brush? _____ How often do you floss? _____

How often do you have your teeth cleaned? _____

How often do you change toothbrushes? _____

PATIENT GOALS

What is your goal for dental treatment today? _____

_____

Are you in discomfort today? ☐ Yes ☐ No

Are you pleased with the appearance of your teeth? ☐ Yes ☐ No If no, please explain _____

_____

Do you like your smile? ☐ Yes ☐ No If no, please explain _____

_____

Does dental treatment make you nervous? ☐ Yes ☐ No If yes, please explain _____

_____

Have you been pleased with your previous dental care? ☐ Yes ☐ No

Have you ever had a bad experience in a dental office? If so, explain _____

_____

How can we help improve your teeth and smile? _____

_____