Davis Family DENTISTRY

Dental History

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

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped 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
- ☐ Braces
- ☐ Periodontal (gum) treatments

Name of Previous Dentist:
_____

City: _____

State: _____

Do you smoke tobacco? ☐ Yes ☐ No

Do you use chewing tobacco? ☐ Yes ☐ No

If you could change your smile, you would:

- ☐ Make my teeth brighter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

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

How important is your dental health?
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

What is most important to you about your dental visit today?
_____
_____
_____

_____ _____
Signature of Patient Date