

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