Dental History

Why have you come to the dentist today? _____

_____

Are you happy with the way your smile looks? _____ if no, please answer the following questions:

Are you currently in pain? ☐ Y ☐N

Manual or Electric toothbrush? Please circle one.

Do you use anything in addition to brushing or flossing? ☐ Y ☐ N

If yes, what? _____

Do your gums ever bleed? ☐ Y ☐ N

Have you ever had periodontal disease? ☐ Y ☐ N

Are your teeth sensitive to heat, cold, or anything else? ☐Y ☐N

When I see a picture of myself:

☐ I wish my teeth were whiter.

☐ I wish I had wider or broader smile.

My teeth are:

☐ Crowded ☐Crooked ☐ Uneven

☐ Overlapped ☐My teeth have rough edges

My gums show:

☐ Too much.

☐ Not enough when I smile.

☐ My top teeth don't show enough.

☐ There is too much space between some of my teeth.

☐ I have discolored areas between my teeth.

☐ I am not totally pleased with my smile.

Previous/Present Dentist: _____

Last Visit Date: _____

What did you like most and least about any dentist you have seen?

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
SIGNATURE _____

The undersigned hereby authorized Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____. And further authorization and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I give permission for release of any pertinent information about my health that may be necessary for proper diagnosis and treatment. You have my permission to use clinical diagnostic materials such as x-rays, models, photographs, etc. for display or teaching purposes.

Signature _____ Date _____