DENTAL HISTORY

Please check any that apply to you:

- o Do you wake up still feeling fatigued?
- o Have you been told you snore or briefly stop breathing?
- o Have you previously taken a sleep study?
- o Do you currently use a CPAP?
- o Do you wear a sleep appliance?

Please check any problems that apply to you:

- o Sensitivity (hot, cold, sweet)
- o Tooth Pain or discomfort chewing
- o Jaw Joint Pain (TMJ)
- o Teeth or fillings breaking
- o Grinding or clenching teeth
- o Bleeding, swollen or irritated gums
- o Loose, tipped or shifting teeth
- o Bad breath or bad taste in mouth

Do you have any of the following?

- o Dentures
- o Partial dentures
- o Braces
- o Periodontal (gum) Disease

If you could change your smile, would you:

- o Make your teeth brighter
- o Make your teeth straighter
- o Close spaces
- o Replace black metal fillings with natural tooth colored fillings
- o Repair chipped teeth
- o Replace missing teeth
- o Replace old crowns that don't match
- o Have a smile makeover

Name of Previous Dentist:

_____

City: _____ **State:** _____

Phone Number: _____

Please share the following dates:

- o Your last cleaning _____
- o Your last set of x-rays _____

Why did you leave your previous Dentist?

_____

_____

On a scale of 1-10, with 10 being the highest (please circle)

How important is your dental health to you
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 thing to you about your future smile and dental health?

_____

_____

What is most important thing about your dental visit with us today?

_____

_____