Name:_____

Dental History

What type of dentistry are you looking for?_____

Why are you now seeking dental treatment?_____

Are you satisfied with your smile?_____

If you could change anything about the appearance of your smile what would it be?_____

_____

How often do you smoke:_____ Sip soda frequently:_____

Floss:_____ Eat Dried Fruits:_____

How likely are you to fall asleep in the following situations?
Rating Scale; 0-would never fall 1-slight chance 2-moderate chance of dozing 3-high chance of dozing

_____Sitting and reading
_____Sitting inactive in a public place
_____Sitting and talking to someone
_____Sitting quietly after lunch
_____Watching TV
_____As a passenger in a car for an hour
_____Lying down to rest in the afternoon
_____In a car while stopped for a few minutes in traffic

Do you have or have you ever had any of the following?

MOUTH		**Yes**	**No**	**Teeth**		**Yes**	**No**
Bleeding, sore gums	O	O		Loose teeth	O	O	
Bad Breath/Unpleasant taste	O	O		Sensitive to hot	O	O	
Burning tongue/lip	O	O		Sensitive to cold	O	O	
Frequent blisters, lips/mouth	O	O		Sensitive when chewing	O	O	
Swelling or lumps in the mouth	O	O		Food impaction	O	O	
Ortho treatment (braces)	O	O		Clenching or Grinding	O	O	
Biting cheeks or lip	O	O		Shifting of teeth	O	O	
Clicking/popping or pain in the jaw	O	O		Change in bite	O	O	
Difficulty opening or closing your jaw	O	O					

Have you ever had any serious trouble associated with previous dental treatment?_____

_____

Does dental treatment make you nervous? _No_____Slightly_____Moderately_____Extremely_

Name of previous dentist:_____ Date of last dental visit:_____
Please circle the following if it applies to you.
Have you ever been treated for: Periodontal Disease Gum Disease Pyorrhea Trench Mouth
When?_____

Tooth Shade: B1 A1 B2 D2 A2 C1 C2 D4 A3 D3 B3 A3.5 B4 C3 A4 C4

Patient Signature:_____ Date:_____