•DENTAL HISTORY•

	YES	NO
How LONG SINCE you have seen a Dentist?		
Last FULL MOUTH X-RAYS, DATE: *(Machine that rotates around your head, or 16 small films.)*		
Are you having PROBLEMS now? Please Explain:	☐	☐
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have any HEADACHES, EARACHES, or NECKPAINS? (circle)	☐	☐
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you have a problem with Bad Breath	☐	☐
Do you have problems with teeth/fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐
If you could whiten your teeth at a price anyone could afford, would you do it ?	☐	☐
Name of Previous Dentist: City: State:		

Date	Remarks	Date	Remarks