

Dr Kelly Blair

COSMETIC & RESTORATIVE DENTISTRY

DENTAL HISTORY

PATIENT NAME: _____ DATE: _____

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

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

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete X-Rays _____

If you could whiten your teeth for a cost you could afford, would you do it? _____

Do you smoke or use chewing tobacco?

How much? _____ **For how long?** _____

If you could change your smile, you would:

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

On a scale of 1-10, with 10 the highest rating:

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

How important is the appearance of your smile?

1 2 3 4 5 6 7 8 9 10

Where would you rate the appearance of your smile?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

Name of last dentist: _____

City/State/Phone _____