

Dental History

Patient Name: _____ Date of Birth: ___/___/___ Age: _____

Please check ALL conditions that apply to your health:

- | | | | |
|---------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Bite or teeth have shifted | <input type="checkbox"/> Unable to open mouth wide | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Broken filling or tooth | <input type="checkbox"/> Often bite cheeks | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Jaw gets tired easily |
| <input type="checkbox"/> Sensitivity to: | <input type="checkbox"/> Frequent dry mouth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Floss breaks easily or hurts |
| <input type="checkbox"/> Cold or <input type="checkbox"/> Hot | <input type="checkbox"/> Concerned about breath | <input type="checkbox"/> Mouth breath – asleep or awake | |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Unusual habits with teeth | <input type="checkbox"/> Clicking or <input type="checkbox"/> Popping of joint | <input type="checkbox"/> Wore braces |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Gums bleed | <input type="checkbox"/> Clench or <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Previous bite treatment |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Gums tender | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Previous TMD treatment |
| <input type="checkbox"/> Food catches | <input type="checkbox"/> Growths or <input type="checkbox"/> Sores | <input type="checkbox"/> Cold sores, fever blisters | <input type="checkbox"/> Whitening teeth |
| <input type="checkbox"/> History of gum surgery or | <input type="checkbox"/> Deep Cleaning (Scaling & Root Planning) Date: _____ | | |

Please rate your smile from 1 to 10 (1 = dislike my smile, 10 = love my smile) 1 2 3 4 5 6 7 8 9 10
If you dislike your smile, please describe what bothers you about the appearance of your teeth or smile?

- Are you interested in Invisalign? Yes No
Would you like to replace missing teeth? Yes No
Would you like to have whiter teeth? Yes No

Please rate how anxious you are about dental treatment? (1 = totally relaxed / severe anxiety) 1 2 3 4 5 6 7 8 9 10

Have you ever had a bad experience at the dentist? Yes No If yes, what happened?

Why did you leave your previous dentist?

At Smile Tucson, we respect your right to choose the level of care that fits your needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office that will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

Please add anything you feel is important:

Signature: _____ Date: _____