Patient Name **Nickname** **Age**

DENTAL HISTORY

What was the **name of your previous dentist**? Where was the office located?

Why are you **changing dentists**?

- ▢ Change of residence
- ▢ Change of dental plan
- ▢ Your office is closer
- ▢ Too expensive
- ▢ My dentist retired/closed
- ▢ Unhappy
- ▢ You were recommended
- ▢ Other:

Please explain:

What is the **reason for your visit**?

▢ Check-up/Cleaning ▢ Filling(s)/Crown(s) ▢ Pain/Discomfort (if so, *where*?) ▢ Other:

Please provide details:

How long has it been since your **last dental visit**?

▢ 1-3 months ▢ 6 months ▢ 1-2 years ▢ 3+ years ▢ I've never seen a dentist ▢ Other:

How long has it been since your **last dental cleaning**?

▢ 1-3 months ▢ 6 months ▢ 1-2 years ▢ 3+ years ▢ I've never seen a dentist ▢ Other:

When was the last time you had **dental x-rays** taken?

What was done at your last dental visit?

PERSONAL HISTORY & SMILE CHARACTERISTICS

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**
Do you feel **nervous** about having dental treatment?	▢	▢
If yes, please *circle* one: slightly, moderately, extremely		
Have you ever had a **bad or upsetting experience** at the dentist?	▢	▢
Have you ever had any **complications** following dental treatment?	▢	▢
Have you ever had an unfavorable **reaction to dental anesthetic**?	▢	▢
Have you ever had **trouble getting numb?**	▢	▢
Do your gums **bleed** when you brush or floss?	▢	▢
Are you aware of **sores** or irritated areas in your mouth?	▢	▢
Have you ever been treated for **periodontal disease**?	▢	▢
Have you had **orthodontic work** (braces, clear aligners) in the past?	▢	▢
Do you like your smile?	▢	▢
Do you participate in **contact sports** or **high speed sports** (skiing, motorcycles, etc)?	▢	▢

If you could change your smile, **what would you like to change**? Please mark all that apply.

- ▢ The color of my teeth/interested in bleaching
- ▢ Close spaces or restore worn and broken teeth
- ▢ The shape of my teeth
- ▢ The position or alignment of my teeth
- ▢ Other

  Please specify:

To ensure your visit is a great experience, please share any **questions or concerns** you would like us to know about.

Signature of Patient or Responsible Party ______________________________ Date ______________