Dental Health History

ARBOR LAKES DENTAL

Patient Name: _____ DOB: _____

Please check Yes or No for those that apply to you.

Yes	No		Yes	No	
☐	☐	Sensivity to: Hot Cold Sweet	☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Chipped / Broken Tooth	☐	☐	Dissatisfied with Appearance of my Teeth
☐	☐	Crooked or Tipped Teeth	☐	☐	Frequent Headaches
☐	☐	Loose Teeth	☐	☐	Jaw Joint Pain
☐	☐	Missing / Spaces Between Teeth	☐	☐	Grinding or Clenching Teeth
☐	☐	Catch food between teeth	☐	☐	Uncomfortable/uneven when I bite my teeth together
☐	☐	Dry Mouth or Consistently Thirsty	☐	☐	Clicking or popping of jaw
			☐	☐	Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

Yes	No		Yes	No	
☐	☐	Dentures or Partials	☐	☐	Veneers
☐	☐	Braces or Clear Braces	☐	☐	Jaw Surgery
☐	☐	Periodontal Disease or Gum Treatments	☐	☐	Root Canals
☐	☐	Fixed Bridge	☐	☐	Sleep Apnea
☐	☐	Dental Implants	☐	☐	C-Pap Machine or Oral Sleep Appliance
☐	☐	Crowns	☐	☐	Fear or Anxiety about Dental Treatment

If I could change my smile, I would:

☐ Make my teeth whiter	☐ Repair Chipped Teeth
☐ Make my teeth straighter	☐ Replace Missing Teeth
☐ Close Spaces or Gaps that Bother Me	☐ Replace Old Crowns that look dark or don't match
☐ Replace Metal Fillings w/Tooth Colored Fillings	☐ Have a smile makeover
☐ Fix my teeth so I'm not embarassed when I smile	☐ Stop my jaw from hurting or clicking

On a scale of 1-10, with 10 being 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

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Have you ever smoked/chewed tobacco? ☐ Yes ☐ No If yes, how much/long? _____

If you could whiten your teeth for as little as a dollar a day, would you be interested? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of: last cleaning ____ / ____ oral cancer screening? ____ /____ last set complete x-rays? ____ / ____

What is the most important thing to you about your dental visit today? _____

What is the most important thing to you about your future smile & dental health? _____

Why did you leave your previous dentist? _____

I certify that the information recorded on this dental form is correct. I understand it is my responsibility to notify Arbor Lakes Dental of anychanges. I understand that if I withhold information regarding allergies, medical conditions, medications or supplements; I agree not to hold Arbor Lakes Dental or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____

Clinician Signature: _____