Time 1:07 PM | Allen Pond Dental PLC | Date 4/23/16

Dental Health History

Patient Name: | Birth Date: | Date Created:

Please check Yes or No for those that apply to you

Sensitivity to Hot, Cold or Sweet	Yes No	Loose Teeth	Yes No	Spaces Between Teeth	Yes No
Chipped/Broken Teeth	Yes No	Missing Teeth	Yes No	Catch Food Between Teeth	Yes No
Dry Mouth or Excessive Thirst	Yes No	Tobacco Use	Yes No	Bleeding, Swollen or Irritated Gums	Yes No
Dissatisfied w/ Appearance of Teeth	Yes No	Frequent Headaches	Yes No	Jaw Joint Pain	Yes No
Grinding or Clenching Teeth	Yes No	Uncomfortable/uneven when biting teeth t	Yes No	Clicking or Popping of Jaw	Yes No
Difficulty Opening or Chewing	Yes No				

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

Full or Partial Dentures	Yes No	Braces or Invisalign	Yes No	Periodontal Disease or Gum Treatments	Yes No
Fixed Bridge	Yes No	Dental Implants	Yes No	Crowns	Yes No
Veneers	Yes No	Jaw Surgery	Yes No	Root Canals	Yes No
Sleep Apnea	Yes No	C-Pap Machine or Oral Sleep Applianc	Yes No	Fear or Anxiety about Dental Treatment	Yes No

If I could change my smile I would:

☐ Make My Teeth Whiter	☐ Make My Teeth Straighter	☐ Close Spaces or Gaps
☐ Replace Metal Fillings w/ Tooth Colored	☐ Fix My Teeth So I Can Smile More	☐ Repair Chipped Teeth
☐ Replace Missing Teeth	☐ Replace Old Crowns that Don't Match	☐ Have a Full Smile Makeover
☐ Stop Jaw from Hurting/Clicking		

On a scale of 1-10, with 10 being the highest rating: How important is dental health to you? _____

On a scale of 1-10, with 10 being the highest rating: Where would you rate your dental health? _____

Please check yes or no for the following:

I would like information for replacing m	Yes No
Have you ever been sedated for dental tr	Yes No
Have you ever whitened your teeth	Yes No

Date of last cleaning? _____

Date of last oral cancer screening? _____

Date of last complete dental xrays? _____

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

Why did you leave your previous dentist? _____

Signature of Patient, Parent or Guardian:

X Date:_____