HOLISTIC DENTAL CENTER

Discover the missing link to better health

Dental History and Information

Patient's Name _____

1. What is the primary reason for your coming to our dental office? _____

_____

2. Are you in pain or discomfort right now? _____
3. Who was your previous dentist? Name _____

   Address _____ Phone _____
4. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
5. Did you once have a bad experience in a dental office? _____
6. When was your: Last dental visit? _____

   Last dental X-rays? _____

   Last cleaning/hygiene? _____
7. Are any of your teeth sensitive to: ☐ Sweets ☐ Cold ☐ Heat ☐ Chewing ☐ Biting ☐ Pressure
8. Do you have or have you ever had any of the following:

Braces	☐ Yes ☐ No	TMJ problems	☐ Yes ☐ No	Bite adjusted	☐ Yes ☐ No
Bad Breath	☐ Yes ☐ No	Difficulty opening or closing	☐ Yes ☐ No	Decreased or Increased saliva	☐ Yes ☐ No
Loose teeth	☐ Yes ☐ No	Clenching	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Clicking, popping in jaw	☐ Yes ☐ No	Burning of mouth or tongue	☐ Yes ☐ No
Food impaction	☐ Yes ☐ No	Metallic taste	☐ Yes ☐ No	Ringing in ears	☐ Yes ☐ No
Change in bite	☐ Yes ☐ No	Gum surgery	☐ Yes ☐ No	Facial pain	☐ Yes ☐ No
Unpleasant taste	☐ Yes ☐ No	Jaw fatigue after chewing	☐ Yes ☐ No	Tenderness near the ear	☐ Yes ☐ No
Itching gums near fillings	☐ Yes ☐ No	Jaw locked open or shut	☐ Yes ☐ No	Bad reaction to anesthetic	☐ Yes ☐ No
Injury to face, jaws, or neck	☐ Yes ☐ No	Wisdom teeth extracted	☐ Yes ☐ No		

SMILE EVALUATION (Use a mirror if necessary):

Do you want to change or improve the appearance of your teeth or smile? _____

_____

Do you want to straighten your teeth? _____ Do you have spaces that you don't like? _____

Are you interested in bleaching your teeth? _____ Changing their shape? _____

Do you have any dental work you don't like the appearance of? _____

What would you like to change about the way your teeth look? _____

_____

_____