Dental Health History

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REVEAL DENTAL
COSMETIC, FAMILY & IMPLANT DENTISTRY

Dental Health History

Patient's First Name *

Patient's Last Name *

Date of Birth *
MM/dd/yyyy

Today's Date
07/08/2024

Please Check Yes (Y) for those that apply to you:

Sensitivity (hot, cold, sweets, pressure) *
○ Yes ○ No

Chipped / Broken Teeth *
○ Yes ○ No

Crooked or Tipped Teeth *
○ Yes ○ No

Loose Teeth *
○ Yes ○ No

Missing or Spaces Between Teeth *
○ Yes ○ No

Catch Food Between Teeth *
○ Yes ○ No

Bad Breath *
○ Yes ○ No

Smoke or Use Chewing Tobacco *
○ Yes ○ No

Bleeding, Swollen or Irritated Gums *
○ Yes ○ No

Dissatisfied with Appearance of My Teeth *
○ Yes ○ No

Frequent Headaches *
○ Yes ○ No

Jaw Joint Pain *
○ Yes ○ No

Grinding or Clenching Teeth *
○ Yes ○ No

Uncomfortable or Uneven When I Bite My Teeth Together *
○ Yes ○ No

Clicking or Popping of Jaw *
○ Yes ○ No

Difficulty Opening or Chewing *
○ Yes ○ No

Please Check Yes (Y) or No (N) if you have, or had any of the following:

Dentures or Partials *
○ Yes ○ No

Braces or Clear Braces *
○ 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 Appliance *
○ Yes ○ No

Fear or Anxiety About Dental Treatment *
○ Yes ○ No

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I would like to learn more about:

- ☐ Whiter Teeth
- ☐ Straighter Teeth
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings with Tooth-Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repairing Chipped Teeth
- ☐ Replacing Missing Teeth
- ☐ Replacing Old Crowns That Look Dark/Don't Match
- ☐ Having a Smile Makeover
- ☐ Stopping My Jaw From Hurting or Clicking
- ☐ Botox/Trigger Point Therapy

On a scale of 1 to 10 with 10 being the highest: (Please circle)

How important is your dental health to you? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How would you rate your current dental health? *

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

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

Date of last cleaning?

MM/dd/yyyy

Date of last oral cancer screening?

MM/dd/yyyy

Date of last complete x-rays?

MM/dd/yyyy

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

Why did you leave your previous dentist?