Dental History

Preferred Name: ______

Have you had any dental treatment, exam or cleaning in the last 3 months? ______

Most recent dental treatment? ______

How was your last dental experience? ______

How often do you have your teeth cleaned? 3 mo ☐ 4 mo ☐ 6 mo ☐ 1 year or longer ☐

What is your immediate dental concern? ______

1. Are you unhappy with the appearance of your teeth?... ☐ yes ☐ no
2. Have you ever had an unfavorable dental experience?... ☐ yes ☐ no
3. Do you have dental fears?... ☐ yes ☐ no
4. Have you had problems/reactions with the effectiveness of dental anesthetic?.......... ☐ yes ☐ no
5. Have you had orthodontic treatment? When?... ☐ yes ☐ no
6. Have you had periodontal (gum) treatment? When?.. ☐ yes ☐ no
7. Do you have tender or bleeding gums?... ☐ yes ☐ no
8. Do you clench or grind your teeth?.. ☐ yes ☐ no
9. Do you experience hot or cold sensitivity?... ☐ yes ☐ no
10. Do you have any sore or loose teeth?.. ☐ yes ☐ no
11. Do you have an unpleasant taste or odor in your mouth?.. ☐ yes ☐ no
12. Do you have dry mouth?.. ☐ yes ☐ no
13. Do you experience any jaw clicking or popping?.. ☐ yes ☐ no

Is there anything about your smile you would like to change? ______

If we could show you an easy way to lighten (whiten) your teeth, would you be interested? ☐yes ☐no

Modern dentistry now allows us to straighten teeth invisibly! Does this interest you? ☐yes ☐no

Is there anything else you would like us to know? ______

I hereby authorize Dr. Roth to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient’s dental needs, and consent to the use of same in scientific papers or demonstrations. I give permission for the release of any pertinent information about my health that may be necessary for proper diagnosis and treatment.

Patient’s Signature ____________________________________ Date ___________________________

Doctor’s Remarks____

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____Dr. Signature_________________________