DENTAL HISTORY

Name: ____

Approximate date of last dental exam: ____________________________

What are your primary concerns? ____________________________________

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Have you had any previous negative experiences at the dentist which we should be aware of?

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Please circle any of the following conditions that apply to you:

Snoring	Jaw Noises	Dry Mouth	Sleep Apnea
Jaw Pain	Oral Piercing	Grinding	Bad Breath
Mouth Breather	Clenching	Wisdom Teeth	Tooth Sensitivity
Nail Biting	Smoker	Smokeless Tobacco	
Floss Daily	Brush Twice Daily		

Please list any other oral habits we should be aware of: ______________________

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Do you drink or use soda, sports drinks or sugar frequently? __________________

Children fluoride vitamins? ____________________________________

Please circle any of the following treatments that you would like further information on:

Full Cosmetic Evaluation	Zoom (in office) Whitening
Eliminate Dark Stains	Tray (at home) Whitening
Eliminate White Stains	OTC Whitening Products
Whiten Single Tooth	Clear Aligner Orthodontics
Close Spaces Between Teeth	Reduce Gummy Smile
Eliminate Crowding	Correct Loose Dentures
Rebuild Worn Teeth	Repair Chipped Teeth
Replace Metal Fillings	Athletic Mouth Guard
Replace Discolored Fillings	Fluoride Supplements

Other: ____

INFORMED CONSENT: WE STRIVE TO INFORM AND EDUCATE YOU CONCERNING ALL PROCEDURES WE PERFORM IN THE OFFICE PRIOR TO THE START OF TREATMENT. IN THE EVENT THAT WE HAVE FAILED TO CONVEY THIS INFORMATION TO YOUR SATISFACTION, PLEASE LET US KNOW. WE HAVE NUMEROUS RESOURCES AVAILABLE TO HELP YOU UNDERSTAND ANY TREATMENT THAT WE OFFER. IT IS IMPORTANT THAT YOU KNOW THE BENEFITS, RISKS, ALTERNATIVE TREATMENT OPTIONS, EXPECTED OUTCOMES, AND CONSEQUENCES OF NOT ACCEPTING TREATMENT PRIOR TO THE START OF ANY DENTAL PROCEDURES.

PATIENT SIGNATURE: ____