All Smiles Dental

Dental History

Patient Name: _____

How did you find out about the office? (Check all that apply) Person Referral (name) ___ Signage/building ___

Internet/Social Media ___ Other _____

Previous Dentist's Name: _____ City/State: _____

Date of last dental visit: _____ Date of last cleaning: _____Date of last x-rays:_____

Do you have any dental problems now? Yes__ No__

If yes, please describe: _____

Do you:

Clench or grind your teeth while awake or asleep? Yes__ No__

Mouth breathes while awake or asleep? Yes__ No__

Have tired jaws especially in the morning? Yes__ No__

Smoke, chew tobacco or use medicinal marijuana? Yes__ No__

Want to keep your teeth Yes__ No__

Are you satisfied with:

Appearance of teeth? Yes__ No__

Whiteness of teeth? Yes__ No__

Shape and position of teeth Yes__ No__

Appearance of dark fillings? Yes__ No__

Have you ever had an upsetting dental experience? Yes__ No__

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____