FRONTIER VILLAGE DENTAL CARE
Cosmetic and Family Dentistry

DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot/cold/sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- Dentures
- Partial Dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last cleaning ____/____
- Your last oral cancer screening ____/____
- Your last complete x-rays ____/____

Name of Previous Dentist_____
City_____ **State** _____
Phone Number: _____

If you could straighten your teeth in 6 months, would you do it?

_____

How often do you floss your teeth?

_____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could change your smile, you would:

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal fillings with natural, tooth colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____
_____

What is the most important thing to you about your future smile and dental needs? _____
_____

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