Patient Name: Date:

Dental History

Do you have a specific dental problem? Describe _____

When was your last dental visit?_____ How often do you brush and floss? _____

Do you think have any cavities or gum disease? ( ) Yes ( ) No Do your gums bleed? ( ) Yes ( ) No

Do you like your smile? ( ) Yes ( ) No Why? _____

Does food catch between your teeth? ( ) Yes ( ) No

Do you have jaw discomfort? ( ) Yes ( ) No Do you grind your teeth? ( ) Yes ( ) No

Do you smoke, chew, vape or use controlled substances? If yes please circle which one(s) ( ) No

Are your teeth sensitive to hot and cold? ( ) Yes ( ) No If yes, where in your mouth? _____

Have you noticed that you have a bad taste in your mouth or bad breath? ( ) Yes ( ) No

Has your doctor told you that you require antibiotics before your dental treatment? ( ) Yes ( ) No

Do you have sleep apnea? ( ) Yes ( ) No Have you ever had a sleep apnea study ( ) Yes ( ) No

Have you ever worn a CPAP? ( ) Yes ( ) No Do you snore? ( ) Yes ( ) No

If you could change your smile would you: (please check any that apply)

( )	Make your teeth whiter	( )	Make your teeth straighter
( )	Close spaces between your teeth	( )	Replace metal/black mercury fillings
( )	Repair chipped teeth	( )	Replace missing teeth
( )	Replace old crowns (color)	( )	Have a smile makeover