Dental History

Date of last Dental Visit:

Section I

1. What is your impression of your oral health? Check one of the following:

___ Good oral health and is not expected to require dental treatment other than a routine dental cleaning or re-evaluation for 6 months.

___ I have some oral conditions, but do not expect these conditions to result in dental emergencies within 6 months if not treated.

___ I have oral conditions that I expect may result in a dental emergency within 6 months if not treated.

- __ a. Infection
- __ b. Cavities / Fillings / Crowns
- __ c. Missing Teeth
- __ d. Periodontal Conditions / Gum Disease
- __ e. Oral Surgery
- __ f. Other: Facial Pain

Section II

1. What don't you like about your teeth? _____
2. Have you thought about whitening? YES NO
3. Are there any spaces between your teeth? YES NO
4. Do you have any crooked teeth and do they bother you? YES NO
5. Do you feel your teeth are too long or too short? YES NO
6. Are you pleased with the shapes and position of your teeth? YES NO
7. Do you like the way your teeth look? YES NO