Patient Name: _____ Date of Birth: _____

Today's Date: _____

Dental History

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

Where would you put your current Dental Health? 1 2 3 4 5 6 7 8 9 10

How important in your Dental Health? 1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and Dental Health? _____

_____

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

_____

When was your last dental visit? _____

Dental History

- Bleeding/Sore Gums/Periodontal Disease ❑
- Bad Breath/Bad Taste ❑
- Burning Tongue or Lips ❑
- Change in Bite ❑
- Clenching/Grinding Teeth ❑
- Clicking or Popping Jaw ❑
- Dentures/Dental Appliance ❑
- Dry Mouth ❑
- Dental Anxiety ❑
- Difficulty Opening/Closing Jaw ❑
- Implant ❑
- Food Impaction ❑
- Loose Tooth/Teeth ❑
- Mouth Guard ❑
- Root Canal Treatment ❑
- Sensitive: Biting ❑
  - Cold/Hot ❑
  - Sweets ❑
- Snoring ❑
- Wisdom Teeth Removed ❑

If I could change my smile I would:

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

The information I have completed on this form is accurate and complete to the best of my knowledge. It is intended only for the use in my treatment. I will not hold Dr. Alexander nor any member of his Team responsible for any errors or omissions that I may have made in completion of this form.

_____

Signature (Patient or Parent/Guardian if under age 18)

Date: _____