

**DENTAL HISTORY – Dr. Gibson will be sure to review any concerns you have with the health of your smile and teeth. Please check anything you would like to discuss further.**

What is the reason for your visit today?

\_\_\_\_\_

- |   |       |  |       |
|---|-------|--|-------|
| Are any of your teeth sensitive to <i>hot or cold</i> ? | _____ | Have you ever had braces?                | _____ |
| Are any of your teeth sensitive to <i>sweets</i> ?      | _____ | Have you ever had oral surgery?          | _____ |
| Any sensitivity to <i>biting or chewing pressure</i> ?  | _____ | Have you ever had surgery?               | _____ |
| Do you notice mouth odors?                              | _____ | Do you wear a bite or "night" guard?     | _____ |
| Do you notice bad tastes?                               | _____ | Any serious injury to the mouth or head? | _____ |
| Do your gums bleed or hurt?                             | _____ | Please describe:                         |       |
| Does food get caught between your teeth?                | _____ |  |       |
| Does your jaw click or pop?                             | _____ |  |       |
| Is this a problem you want corrected?                   | _____ | Any pain in your jaw joint?              | _____ |
| Do you clench or grind your teeth?                      | _____ | Frequent headaches?                      | _____ |
| Do you ever notice tired jaws or sore teeth?            | _____ | Frequency and time of day of headaches:  | _____ |
| Do you smoke or chew tobacco?                           | _____ | Are you currently missing any teeth?     | _____ |

Do you feel nervous about dental treatment? If so, what are your concerns?

Is this a problem you want corrected?                      Yes    No

Date of: Last Dental Visit? \_\_\_\_\_ Last Cleaning? \_\_\_\_\_ X- rays? \_\_\_\_\_

What was done at your last dental visit?  
\_\_\_\_\_

Previous Dentists Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Your reason for leaving their office:  
\_\_\_\_\_

What did you *like* about your previous dental experiences?  
\_\_\_\_\_

What did you *dislike* about your previous dental experiences?  
\_\_\_\_\_

How often do you normally have dental examinations?  
Once per year      Twice per year    Three times per year      More

How often would you prefer dental examinations?    Once per year      Twice per year      Three times per year      More

Would you like to discuss your options to enhance your smile? (i.e. whiter, straighter teeth.)    Yes    No

If yes, what are your goals &

expectations? \_\_\_\_\_

Are you concerned about your silver-mercury fillings?    Yes    No

Is there anything else / other dental concerns we have not asked about that you want us to

know? \_\_\_\_\_

How can we make each of your future visits more

enjoyable? \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*PLEASE COMPLETE THE OTHER SIDE.    THANK YOU.*