SOUTHERN SMILE STUDIO

DENTAL HISTORY

- WHAT IS THE REASON FOR YOUR VISIT TODAY?_____
- DATE OF YOUR LAST DENTAL VISIT _____
- WHAT WAS DONE AT THAT VISIT? _____
- DATE OF LAST DENTAL CLEANING_____
- DATE OF LAST DENTAL XRAYS_____
- PREVIOUS DENTIST'S NAME _____PHONE _____
  ADDRESS _____
- HOW OFTEN DO YOU VISIT THE DENTIST?_____
- HOW OFTEN DO YOU BRUSH YOUR TEETH?_____
- WHAT DENTAL PROBLEMS DO YOU HAVE AT PRESENT?_____
- ARE YOU HAPPY WITH YOUR SMILE?_____
- IS THERE ANYTHING ABOUT YOUR SMILE THAT YOU WOULD CHANGE?_____
  _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

____ TEETH SENSITIVE TO HOT
____ TEETH SENSITIVE TO COLD
____ TEETH SENSITIVE TO SWEETS
____ BLEEDING OR SORE GUMS
____ LOOSE TEETH
____ BAD TASTE OR ODOR
____ FREQUENT HEADACHES
____ FOOD PACKING BETWEEN TEETH
____ ORTHODONTIC TREATMENT
____ ORAL SURGERY
____ PERIODONTAL TREATMENT
____ WEAR BITE APPLIANCE
____ INJURY TO HEAD, NECK, OR JAWS
____ SORE JAW JOINTS
____ GRIND TEETH

ALL OF THE ABOVE INFORMATION IS TRUE. I WILL NOT HOLD THE DENTIST OR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN THIS FORM.

Patient Signature:_____ Date:_____