

Who referred you to our office? \_\_\_\_\_

## Dental History

What is the reason for this visit? \_\_\_\_\_

Are you aware of any specific dental problems? \_\_\_\_\_

When were your last full mouth X-rays? (15-20 films) \_\_\_\_\_

What is your opinion on the condition of your teeth? POOR NEUTRAL GOOD

How do you feel about the appearance of your teeth? POOR NEUTRAL GOOD

**Please mark YES or NO for the following questions:**

Are you interested in whitening (bleaching) your teeth?   Yes   No

Is there anything about your smile you would like to change?  Yes   No

Have you ever been treated for periodontal disease?     Yes   No

Do your gums bleed when you brush?     Yes   No

Do your gums bleed when you floss?     Yes   No

Do you smoke? How much? \_\_\_\_\_   Yes   No

Does dental treatment make you nervous?     Yes   No