

Canyon State Dental

JAY M. BHATT DDS & ZACK WALTON DMD

Patient Name: _____ Birth Date: _____

DENTAL HEALTH HISTORY

Name of your former dentist: _____ How long since you were last seen? _____

How important is it for you to keep your teeth? 1 2 3 4 5 6 7 8 9 10 Why? _____

On a scale of 1-10, 10 being the best, where would you rate your smile? _____

On a scale of 1-10, 10 being the best, where would you rate your oral health? _____

Have you experienced any of the following?

- | Y | N | | Y | N | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums? | <input type="checkbox"/> | <input type="checkbox"/> | Sensitivity to hot and cold? |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath or sour taste in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | Snoring? |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning sensations in mouth? | <input type="checkbox"/> | <input type="checkbox"/> | Food catching between teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Soreness in jaw or mouth? | <input type="checkbox"/> | <input type="checkbox"/> | Clenching or grinding of teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is it hard for you to open wide? | <input type="checkbox"/> | <input type="checkbox"/> | Pain/soreness around teeth, ears, eyes, face? |
| <input type="checkbox"/> | <input type="checkbox"/> | Clicking or popping in jaw? | <input type="checkbox"/> | <input type="checkbox"/> | Stiff neck muscles? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you/your parents suffered from gum disease? | <input type="checkbox"/> | <input type="checkbox"/> | Do you or your parents wear dentures/partials? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you ever wear braces? | <input type="checkbox"/> | <input type="checkbox"/> | Ever been injured in the mouth or head? |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral surgery of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged bleeding following extractions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the brightness of your teeth important to you? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does having dental treatment make you afraid or nervous? If yes, what specific things bother you? | | | |

If you could change anything about your smile which of the following would you want? *(Please check the box(es))*

- | | | |
|---|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Close space or spaces | <input type="checkbox"/> Replace chipped teeth |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Replace old crowns | <input type="checkbox"/> Remove silver fillings |
| <input type="checkbox"/> Remove stains/spots on teeth | <input type="checkbox"/> Replace old plastic fillings | <input type="checkbox"/> Straighter |
| <input type="checkbox"/> Less gum showing | <input type="checkbox"/> Reshape/resize my teeth | |

Which are important to you when making your dental decisions? *(Please check the box(es))*

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Convenience | <input type="checkbox"/> Appearance | <input type="checkbox"/> Relationship with Dental Team |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Time | <input type="checkbox"/> Quality of care |
| <input type="checkbox"/> What insurance covers | <input type="checkbox"/> Health | <input type="checkbox"/> Detailed treatment explanations |
| <input type="checkbox"/> Fear or Anxiety | <input type="checkbox"/> Comfort | <input type="checkbox"/> Technology |
| <input type="checkbox"/> Other _____ | | |