Burkburnett
Family Dental
your smile our passion

Dental History

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

If new to our office, please share the following dates and information:

Your last cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete set of x-rays _____/_____
Name of previous Dentist:

_____
City: _____
State: _____
Phone: _____

Why did you leave your previous dentist?

_____
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

If you could change your smile, you would

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

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

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current 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?

_____
_____

Person to Be Contacted in Case of Emergency

Name: _____

Address: _____

Telephone: (Home) _____ (Cell) _____ (Work) _____