MANSFIELD DENTAL CENTER

Dental History

Patient Name: _____ **Date:** _____

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, or jaw joint 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
- ☐ Ulcers or mouth sores
- ☐ Snoring
- ☐ Chipped teeth

Do you have, or have you had any of the following:

- ☐ Denture
- ☐ Partial dentures
- ☐ Implants
- ☐ Braces
- ☐ Gum Treatments
- ☐ Night or Bite Guard
- ☐ Sleeping Device. Please specify: _____

Please share the date of your last cleaning: _____

Name of previous Dentist: _____

City: _____ State: _____

Office Phone Number: _____

Why did you leave your previous dentist? _____

_____

_____

What do you value the most out of your dental care?
(Please check all that apply)

- ☐ **COSMETIC**: To have confidence when I talk or smile
- ☐ **FUNCTION**: The ability to enjoy eating my favorite foods
- ☐ **COMFORT**: Having no pain with my teeth or gums
- ☐ **LONGEVITY**: To have my natural teeth for as long as I can

What is the biggest obstacle you have regarding your dental care? (Please check all that apply)

- ☐ **FEAR**: Scared of the pain or environment
- ☐ **TIME**: Having a tight schedule or work conflict
- ☐ **NO URGENCY**: Nothing hurts so I never felt the need to go
- ☐ **BUDGET**: Having the funds to proceed with my dental care
- ☐ **NO TRUST**: Feeling ripped off or bad experience

Do you smoke, use chewing tobacco, or vape?

☐ YES ☐ NO

If yes, how much and for how long? _____

_____

_____

If I could, I would… (Please check all that apply)

- ☐ I would make my teeth whiter
- ☐ I would make my teeth straighter
- ☐ I would close spaces
- ☐ I would replace metal fillings with natural tooth-colored filings
- ☐ I would repair chipped teeth
- ☐ I would replace missing teeth
- ☐ I would replace old crowns that don't match
- ☐ I would have a complete customized smile makeover

On a scale of 1-10, with 10 being 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? _____

_____

_____