

**Your Dental History**

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

Would you be interested in whitening your teeth?  Yes  No

Why did you leave your last dentist? \_\_\_\_\_

If you had a magic wand, what one thing would you do to your teeth? \_\_\_\_\_

What's the worst thing that ever happened to you in a dental office? \_\_\_\_\_

What's the best thing that ever happened to you in a dental office? \_\_\_\_\_

Are you having any discomfort at this time?  Yes  No Describe \_\_\_\_\_

How long has it been since your last dental visit? \_\_\_\_\_

What was done? \_\_\_\_\_

When was your last set of x-rays? \_\_\_\_\_ Do you feel you have bad breath?  Yes  No

Does food get caught in between your teeth?  Yes  No Do your gums bleed?  Yes  No

Do you clench your teeth?  Yes  No

**OFFICE USE ONLY**

Date \_\_\_\_\_ No Change \_\_\_\_\_

Date \_\_\_\_\_ No Change \_\_\_\_\_

Date \_\_\_\_\_ No Change \_\_\_\_\_

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Date \_\_\_\_\_ No Change \_\_\_\_\_

**NOTE CHANGES IN MEDICAL HISTORY**

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