Dental History For: _____

(Patient Name)

How may we help you today (your concern for today's visit)? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Are you currently in pain? ❑ Yes ❑ No
Have you ever had gum treatment? ❑ Yes ❑ No
Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No
Are you under stress? (i.e. new job, moving, relationships) ❑ Yes ❑ No
Do you like your smile? ❑ Yes ❑ No
Is there anything you would like to change about your smile? ❑ Yes ❑ No
Are you happy with the color of your teeth? ❑ Yes ❑ No
Do your gums bleed? ❑ Yes ❑ No
How many times a do you: floss/week? _____ brush/day? _____
Are your teeth sensitive to hot, cold or anything else? ❑ Yes ❑ No
Have you lost any teeth? ❑ Yes ❑ No
Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No
Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____
When was your last dental visit? _____
Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at New Season Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Dental Implants	Invisalign
Sealants	Crown and Bridge	Veneers
Partials/Dentures	Night/Sports Guards	Oral Sedation
Smile Makeover		