

# Loudoun Dental Smiles

## DENTAL HISTORY

Patient's Name \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

When was your last dental exam? \_\_\_\_\_ Previous Dentist's name: \_\_\_\_\_

What was your reason for transferring? \_\_\_\_\_

What did you like most/least about your former dental office? \_\_\_\_\_

How often do you? 1. Have dental exams and cleaning? \_\_\_\_\_ 2. Brush your teeth? \_\_\_\_\_ 3. Floss your teeth? \_\_\_\_\_

### ***Are your teeth sensitive to:***

Hot, cold, sweets?  Yes  No

Biting or Chewing  Yes  No

Do you ever have mouth odor or bad taste?  Yes  No

Do your gums bleed or hurt?  Yes  No

Do you have a history of gum disease in your family?  Yes  No

Does food tend to get caught between your teeth?  Yes  No

If yes, Where? \_\_\_\_\_

### ***Have you ever had:***

Orthodontic treatment?  Yes  No

Jaw surgery?  Yes  No

Periodontal treatment?  Yes  No

### ***Have you ever experienced:***

Clicking or popping of your jaw?  Yes  No

Pain? (joint, ear, face)  Yes  No

Headaches/neckaches?  Yes  No

### **SMILE EVALUATION**

Is there anything you would like to change about your smile ?  Yes  No

Do you have a desire for whiter/brighter teeth?  Yes  No

Do you clench or grind your teeth while asleep or awake?  Yes  No

Do you mouth breathe while asleep or awake? \_\_\_\_\_  Yes  No

I understand the above information is necessary in to provide safe, effective dental care. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I authorize this office to administer such medications and perform such diagnostic/therapeutic procedures as may be necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Responsible Party/Insurance**

(if patient is spouse or minor)

Insurance Subscriber Name \_\_\_\_\_ Phone \_\_\_\_\_

SS No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_