TENNESSEE CENTERS FOR LASER DENTISTRY

DENTAL HISTORY

Patient Name:_____ Date of Birth_____

Please check the boxes that apply to you:

☐ Sensitivity (hot, cold, sweet) ☐ Headaches, Earaches, Neckpain ☐ Jaw Joint Pain

☐ Loose, Chipped or Shifting Teeth ☐ Bleeding, Swollen or Irritated Gums ☐ Grinding or Clinching

☐ Teeth or Fillings Breaking ☐ Bad Breath or Bad Taste in Mouth

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

☐ Dentures ☐ Partials ☐ Braces ☐ Invisalign ☐ CPAP ☐ Periodontal Treatment

Please Share the Following Dates:

Date of last dental cleaning? Date of last Oral Cancer Screening? Date of last X-Rays?

_____ _____ _____

Previous Dentist Information:

Previous Dentist Name: _____ Office Phone Number:_____

Address:_____ Reason for leaving:_____

Please answer the following:

What is the most important thing to you about your dental visit today?

What is the most important thing to you about your future smile & dental health?

If you could whiten your teeth for a price anyone could afford, would you do it? Yes ◯ or No ◉

Do you want to have your entire mouth disinfected during your visit with the Hygienist? ($39) Yes ◯ or No ◉

Do you want a team member to perform an oral cancer screening with the OralID? ($26) Yes ◯ or No ◉

Do you smoke or use chewing tobacco? Yes ◯ or No ◉

If you could change your smile, you would:

☐ Brighten my teeth ☐ Straighten my teeth ☐ Repair chipped teeth ☐ Replace missing teeth

☐ Replace old crowns that don't match ☐ Have a smile makeover ☐ Close spaces in smile

☐ Replace black metal fillings with natural tooth colored fillings

Signature: _____

Name (please print): _____ *Date of Signing:* _____