

Advanced Dental Artistry

Dental History

This form is used so that we can personalize your dental care and cater to your needs.
This information is usually very helpful.

1. What can we do to help you?

2. How long has it been since your last dental appointment? _____

3. Have you had problems with prior dental treatment? Yes No

4. Are you in pain now? Yes No

5. Do you have pain, clicking or popping in your jaw joint (TMJ)? Yes No

6. How nervous are you about coming to the dentist? (Please Circle One)

Very Nervous / A Little Nervous / Not Nervous at All

7. How much would you like to learn about dentistry? In other words, how much would you like the doctor to tell you about what he is doing? (Please Circle One)

Every Little Detail / A Little Bit / Nothing at All

8. Are you happy with the way your smile looks? Yes No

If not, what would you change?

9. Would you be interested in whitening (bleaching) your teeth? Yes No

10. Would you like to learn more about how you can improve your smile? Yes No

12. Would you prefer a neck pillow during your dental appointments? Yes No

11. How did you hear about us? _____

Name: _____

Signature: _____ Date: _____