Osprey Dental, LLC
DENTAL HISTORY

Please check any of the following problems that apply to you:

Sensitivity to: Hot Cold Sweet Pressure

Where? UR LR UL LL

☐Headaches, earaches, neck pain

☐Jaw joint pain

☐Teeth or fillings breaking

☐Grinding or clenching teeth

☐Bleeding, swollen or irritated gums

☐Loose, tipped or shifting teeth

☐Bad breath

On a scale of 1 – 10 with 10 being the best:
How important is your dental health to you?______________
Where would you rate your current dental health?_________
Where do you want your dental health to be?_____________

If you could change your smile, would you:

☐Make them whiter

☐Make them straighter

☐Close spaces

☐Replace black metal fillings w/ tooth colored restorations

☐Repair chipped teeth

☐Replace missing teeth

☐Replace old crowns that don't match

☐Have a smile makeover

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

☐Dentures/Partial Dentures

☐Dental implants

☐Braces

☐Periodontal (Gum) treatment

When was your last cleaning?______________________________________
When was your last complete set of xrays?____________________________
Name of previous Dentist?____
Why did you leave your previous Dentist?_____________________________
What is the most important thing to you about your future smile and dental health?
____
What is the most important thing to you about your dental visit today?____

Patient Name Printed:	Date:
Patient Signature (Parent if Child):	Date: