Emerald
DENTAL STUDIO

Dental History Form

Last Name:_____ First Name:_____ Birth Date:_____

1. What is your main concern for coming to our office today?_____

2. What is important to you in a dental practice?_____

3. What has been your experience with the dentist in the past?_____
_____

4. Approximate date of your last x-rays?_____

5. Approximate date of your last cleaning?_____

6. Reason for leaving your previous dentist:_____

7. Former Dentist and/or city:_____

8. Have you had problems with prior dental treatment?_____

9. Are you experiencing any pain now? Please describe:_____
_____

Anxiety Level (check one): __very nervous __slightly nervous __not nervous at all

Please share why you might be nervous:_____

What concerns do you have with your health or smile? (check all that apply)

_ jaw joint pain	_ unhappy with appearance	_ loose tooth/teeth
_ clenching/grinding	_ discolored teeth	_ bad breath
_ crowded/crooked teeth	_ old fillings/crowns	_ food gets caught
_ spaces/gaps in teeth	_ hot/cold sensitivity	_ other:_____

Have you ever had orthodontics (braces, Invisalign, clear aligners)? _ Yes _ No

Have you ever had your wisdom teeth molars removed? _ Yes _ No

Have you ever had periodontal (gum) treatment (deep cleanings or gum surgery)? _Yes _ No

What method have you used to whiten your teeth in the past?_____

Are you interested in learning more about the following? (check all that apply)

__ Teeth Whitening	__ Veneers	__ Preventing gum disease
__ Ortho/Clear aligners	__ Implants	__ Night Guard