Dental History/Personal Interest

Welcome! So that we may provide you with the best possible care and form a long lasting relationship, please complete this Dental history/Personal interest form. All information is completely confidential.

Patient Name:_____Date:_____

- What is the reason for your dental visit today?_____
  _____
- How did you hear about us; Check all that apply:

  ___Google.com
  ___Yelp
  ___Angie's List
  ___Kaliherdentistry.com
  ___DoctorOogle.com
  ___Family member/Friend
  ___Received our brochure in the mail
  ___Neighborhood Association newsletter
  ___Austin Chamber of Commerce
  ___Other
- Date of your last dental visit_____Last Dental Cleaning_____
  Last Full Mouth X-Rays_____
- Previous Dentist Name_____
- Address:_____
  State:_____Zip:_____
- Telephone :_____
- I am changing Dentist's because:_____
  _____
- How often do you have dental examinations?_____
- How often do you brush?_____How often do you floss?_____
- Have you ever used or are currently using topical fluoride? Yes No
- What other dental aids do you use?(Toothpick, Waterpik,Etc)_____
- Do you have any dental problems now? Yes No
  If yes, please describe:_____
- Where are you originally from? _____
- What is your occupation/job?_____
- What's more fun than a dental visit?_____
  _____

(Continued on next page)

Dental History/Personal Interest

Are any of your teeth sensitive to:

Sweets Yes No
Hot or cold Yes No
Biting or chewing Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters, or any other oral lesions? Yes No
Do your gums ever bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes, where?_____.

Do You:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleeping disorders? Yes No
Smoke/chew tobacco or use any other tobacco products? Yes No
Dream of teeth falling out? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground on or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If yes, please describe, including cause:_____
_____.

Have you experienced:

Clicking or popping of jaw? Yes No
Pain in jaw joint or ear side of the face? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Difficulty in opening or closing mouth? Yes No
Headaches, neck aches or shoulder aches? Yes No
Sore muscles? Yes No

Are your satisfied with your teeth and their appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No
Do you feel nervous about having dental treatment? Yes No

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Dental History/Personal Interest

If yes, what is your biggest reason for avoiding care in the past?

___Time commitment

___No perceived need

___Financial commitment

___ Trust Factor

___Other: please explain_____

Have you ever had an upsetting dental experience? Yes No

If yes, please explain:_____

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

If yes, please describe:_____

_____

Are you interested in exploring (Check all that apply)

___Link between Periodontal Disease and Heart Disease

___Teeth whitening-Deep bleaching (KOR)

___Oral B Professional electric toothbrush

___ Sedation dentistry (pill form) options

___Smile makeover-Smile analysis and design