Office of Sally Kashani Dental History Form (Optional)

Date: _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

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

Date of last radiographs (x-rays) and exam: _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)*: _____

Former Dentist Phone: _____

Address: _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? No **If yes describe** _____

Have you ever been pre-medicated with antibiotics for dental treatment? No **If yes, why** _____

Have you been anxious about having dental treatment? No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

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

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Missing teeth
- ☐ Difficulty chewing
- ☐ Spaces in between teeth
- ☐ Too much gum when I smile
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Old fillings (silver or gold)
- ☐ Old crowns
- ☐ Loose tooth/teeth
- ☐ Other
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food gets caught in between teeth
- ☐ Crowding or crooked teeth
- ☐ Tooth shape or size
- ☐ Bad breath
- ☐ Speech problems

Do you ever get cold sores or canker sores? No

If yes are you interested in pain alleviation and minimizing time of sores? No

Have you ever had orthodontic treatment? No **If yes, when?** _____

Have you ever had periodontal *(gum tissue)* **treatment -deep cleanings, root planing or periodontal surgery?** No

If yes, when? _____

Have you ever whitened your teeth in the past? No **If yes, home or in-office method?** _____

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

- ☐ Teeth whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth colored fillings
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At home hygiene care
- ☐ Periodontal treatment during pregnancy

This document is filled out to the best of my knowledge to be true and correct

_____

Patient signature