Steven S. Lawson DDS INC
Creating Healthy Smiles

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Dental Health History

Name_____Date of Birth_____

What is the reason for your visit today? _____

Yes No Have you ever been pre-medicated for dental treatment?

Yes No Have you ever had braces? When? _____

Yes No Have you ever had gum treatment? When? _____

Yes No Have you noticed any mouth odor or bad taste?

Yes No Do your gums ever bleed?

Yes No Do you clinch or grind your teeth while awake or asleep?

Yes No Do you snore or have sleeping disorders?

Yes No Do you have dry mouth?

Are your teeth sensitive to: ___ Hot ___ Cold ___ Biting or chewing

Previous Dentist _____Phone _____

Address *:(if out of area)* _____ City _____State___ Zip_____

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

Date of last visit_____ Date of last cleaning or gum treatment _____ Date of last full mouth x-rays _____

Would you like to keep your teeth for the rest of your life? _____ Did your mother? _____ Did your father? _____

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

Have you had problems with prior dental treatment? _____

What would you like to change about your teeth? ___whiter ___straighter ___remove silver fillings ___implants ___veneers

___bite ___places food catches ___ spaces between teeth Other_____