Stacey Gividen, DDS – Justin Simmons, DDS – 710 N. 1st Street, Hamilton MT 59840 – (406) 375-1192

Dental History Information

First Name:_________________________________ **Last Name:**_________________________________ **Today's Date:** _______________

To ensure that you have the best dental care possible, please fill out this form to the best of your ability...

1. What brings you to our office today?

____

2. Are you currently in pain? Y or N
Explain:

____
____

3. Have you ever had a serious or difficult problem associated with your dental work? Y or N
Explain:

____
____

4. How often do you brush your teeth? _________Day/week

5. How often do you floss? _________Day/week

6. Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, or shifting teeth
- ☐ Bad breath or taste in your mouth

7. Do you have/had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Orthodontics
- ☐ Periodontal Treatments

8. Please share the following dates (if able)

Last cleaning? ___________________

Last Pano/FMX? ___________________

9. On a Scale of 1-10,

How would you rate your current oral health?
1 2 3 4 5 6 7 8 9 10

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

10. If you could change your smile you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns
- ☐ Have a smile makeover

11. What is the most important thing to you about your dental visit?

____
____

12. Why did you leave your previous dentist?

____
____

Name of Previous Dentist?

____

City: ______________ State: ____________

Phone: ________________________

I have completed this form to the best of my ability:

Patient signature:

____

Date:

____