Hillview Family Dentistry

119 Topfield Rd
Louisville, KY 40229
502-957-4408

Dental History

Any sensitivity? (Y/N) ________ (Hot, Cold, Sweet)
Where? UL, UR, LL, LR
Headaches, earaches, neck pain, jaw joint pain? (Y/N) ________
Teeth or fillings breaking? (Y/N) __________
Grinding or clenching teeth? (Y/N) _______
Bleeding, swollen or irritated gums? (Y/N) _________
Loose, Tipped or shifting teeth? (Y/N) ________
Bad Breath? (Y/N) ________
Do you have, or have you had any of the following? (Y/N) ________
Denture, Partial dentures, Braces, Periodontal (gum) disease?

Your last cleaning? ________________________________
Your last oral cancer screening? ______________________

Do you smoke or use chewing tobacco? (Y/N) ________
How much? ___________ How Long? __________
If I could change my smile, I would: (circle)
Make them whiter
Make them straighter
Close Spaces
Replace black metal fillings with tooth colored restorations
Replace old crowns that don't match

Your previous Dentist? __________________________
City:____________________ State: ______________________

On a scale of 1-10 10 being the highest rating:

How important is your dental health to you? __________________

Where would you rate your current dental health? _____________

Where do you want your dental health to be? _________________

Why did you leave your previous dentist? _______________________________

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What is the most important thing to you about your future smile and dental health?
____
What is the most important thing to you about you dental visit today?
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