Michael Kim DDS

Dental Health History

Patient First Name | Patient Last Name | Date

Please check Yes or No for those that apply to you.

YES	NO		YES	NO	
☐	☐	Sensitivity to: Hot Cold Sweet	☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Chipped / Broken Teeth	☐	☐	Dissatisfied With Appearance of My Teeth
☐	☐	Crooked or Tipped Teeth	☐	☐	Frequent Headaches
☐	☐	Loose Teeth	☐	☐	Jaw Joint Pain
☐	☐	Missing or Spaces Between Teeth	☐	☐	Grinding or Clenching Teeth
☐	☐	Catch Food Between Teeth	☐	☐	Uncomfortable or Uneven When I Bite My Teeth Together
☐	☐	Dry Mouth or Constantly Thirsty	☐	☐	Clicking or Popping of Jaw
☐	☐	Smoke or Use Chewing Tobacco	☐	☐	Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

YES	NO		YES	NO	
☐	☐	Dentures or Partials	☐	☐	Veneers
☐	☐	Braces or Clear Braces	☐	☐	Jaw Surgery
☐	☐	Periodontal Disease or Gum Treatments	☐	☐	Root Canals
☐	☐	Fixed Bridge	☐	☐	Sleep Apnea
☐	☐	Dental Implants	☐	☐	C-PAP Machine or Oral Sleep Appliance
☐	☐	Crowns	☐	☐	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Where would you rate your current dental health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

Have you ever whitened your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the most important thing to you about your dental visit today: _____

Why did you leave your previous dentist? _____