AGAVE DENTAL

Dental History

What are your main dental concerns today? _____

Are you currently in pain or discomfort with your teeth and/or gums? ❑ Yes ❑ No _____

How would you describe the condition of your teeth and gums? ❑ Excellent ❑ Fair ❑ Poor

Last Dental Visit Date: Previous Dentist:

Do you have headaches? ❑ Yes ❑ No If YES, how often?

Have you had orthodontics? ❑ Yes ❑ No If YES, at what age?

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Questionnaire

Gums

❑ Y ❑ N Do your gums ever bleed?

❑ Y ❑ N Have you ever had a "deep cleaning"?

❑ Y ❑ N Have you ever been told you have gum disease?

Joints

❑ Y ❑ N Do you grind or clench your teeth?

❑ Y ❑ N Have you ever had pain/discomfort in your jaw joint? Lock jaw?

❑ Y ❑ N Do you have muscle pain in your face/neck?

❑ Y ❑ N Do you snore or have you been told you do?

❑ Y ❑ N Do you sleep well? How many hours? _____

Esthetics

❑ Y ❑ N Would you like to have whiter teeth?

❑ Y ❑ N Would you like your teeth to be straighter?

❑ Y ❑ N Are you unhappy with any silver or discolored fillings?

❑ Y ❑ N Do you have crowns or bridges which are unattractive or unnatural looking?

❑ Y ❑ N Do you sometimes feel uncomfortable with the appearance of your smile?

❑ Y ❑ N Are you afraid or anxious to visit the dentist?

Do you have any additional concerns that you would like to discuss with the doctor? _____

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Agave Dental for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: **Date:**