Rocky Mountain Dental Group
www.RockyMountainDentalGroup.com
(303)233-1335 • 2475 Wadsworth Blvd, Lakewood, CO 80214

Dental History

Patient's Name:_____ Date:_____

How do you consider your current dental health? (Circle One) Excellent Good Fair Poor

Are your teeth sensitive to: (Circle One) Hot Cold Not Sensitive

Circle any of the following that you currently have or have had previously:

Bleeding Gums Blisters on lips or mouth Dry Mouth Grinding Jaw Pain

Food collecting between the teeth Swollen or Tender gums Mouth Breathing

Orthodontic Treatment Periodontal (gum) Treatment

How many times a day to you brush? ____/day How often do you floss? ____/week

Do you use a power toothbrush? (Circle one) Yes No

Smile Assessment

How happy are you with your smile? 1 2 3 4 5 6 7 8 9 10
(Not Happy) (Very Happy)

If you are not happy with your smile, what bothers you? (Circle all that apply)

Crooked/crowded teeth Gaps in teeth Shape of teeth Color of teeth

Old crowns/fillings "Gummy" smile Other: _____

Are you happy with the color of your teeth? (Circle One) Yes No

Would you like more information about:

Invisalign In-Office Whitening Take Home Whitening No Information Needed