DAVID ROSS, DMD
J LAWRENCE EARL, DMD
FINE DENTISTRY

yousmile@finedentistrynv.com
5280 South Eastern Ave, Suite C-1 Las Vegas, NV 89119
Finedentistrynv.com

Dental History

Why did you leave your last dental office?
(Check all that apply)

- ☐ Move to a new location
- ☐ Insurance
- ☐ Personality difference
- ☐ Second opinion
- ☐ Inadequate care
- ☐ Financial
- ☐ Wanted a change

Date of your last dental visit? _____

Please check any that apply to you

- ☐ Broken teeth or fillings
- ☐ Missing teeth
- ☐ Sensitive teeth
- ☐ Painful teeth
- ☐ Mouth sores or ulcers
- ☐ Dry mouth
- ☐ Bad breath or bad taste in mouth
- ☐ Bleeding or sore gums
- ☐ Crooked teeth
- ☐ Popping or clicking in jaw joint
- ☐ Pain on chewing or opening mouth
- ☐ Clench or grind
- ☐ Recurring sore throat
- ☐ Tenderness in neck or face muscles

Are you interested in any of the following?

- ☐ Invisalign (invisible braces)
- ☐ Tooth whitening, in office or take home
- ☐ Oral sedation (take a pill)
- ☐ How to treat periodontal disease
- ☐ Cosmetic dental treatment
- ☐ Smile makeover
- ☐ Dental wellness and at home dental care
- ☐ Local restaurants or activities
- ☐ Dental Implants
- ☐ Fixed Bridges
- ☐ Removable bridges or dentures

Dental Concerns:

- ☐ I gag easily
- ☐ I get anxious at the dentist
- ☐ Pain relief is my top priority
- ☐ I don't like shots, I have had bad reaction to shots
- ☐ I don't like the sound of dental instruments
- ☐ I don't like cotton in my mouth
- ☐ I don't like dental office smells
- ☐ Respect my time
- ☐ I don't like being left alone in treatment area
- ☐ I have back problems
- ☐ I don't like being tipped too far back in chair
- ☐ Other_____

If I could change anything about my mouth it would be? _____

_____

How often do you brush your teeth? _____ Do you floss regularly? _____

Do you use an electric toothbrush, what kind? _____

What is most important in your dental care? _____

_____

Authorization and Release:

I certify that I have read the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature of patient (or parent/guardian if minor)_____ Date_____