O'NEAL SMILES, LLC
Brandon K. O'Neal, DMD

Dental History

1. Date of Last Dental Visit: _____ Reason for this Visit: _____
2. Have you ever had any complications following dental treatment? Yes ☐ No ☐
   If yes, please explain: _____
3. Do you have any concerns about previous dental care or this dental visit? Yes ☐ No ☐
   If yes, please explain: _____
4. Do your gums bleed? Yes ☐ No ☐
5. Are your teeth loose? Yes ☐ No ☐
6. Have you ever been told that you have bad breath? Yes ☐ No ☐
7. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure
9. Do you feel your teeth are starting to get longer? Yes ☐ No ☐
10. Do you get food stuck between your teeth easily? Yes ☐ No ☐
11. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes ☐ No ☐
12. What would you change about the condition of your mouth? _____
    _____
13. Please check any statement that you agree with about your smile:

    ☐ I wish my teeth were whiter.
    ☐ I wish I had a bigger smile.
    ☐ I think some of my teeth are too small.
    ☐ I think some of my teeth are too large.
    ☐ I wish my teeth were straighter.
    ☐ My gums show too much when I smile.
    ☐ I think there is too much space between some of my teeth.
    ☐ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
    ☐ I have often wished I could change some of the features of my smile.
    ☐ I think I need to do a better job of protecting the health of my smile.

_____ _____
Signature of Patient, Parent or Guardian Date