Batesville Dentistry

310 Highway 51 South | Batesville, MS 38606 | 662.563.9550

Dental History: Check to indicate if you have or have had any of the following:

Bad breath	○	Grinding Teeth	○
Bleeding gums	○	Jaw Pain	○
Dry Mouth	○	Pain around Ear/Joints/Side of Face	○
Gums Swollen/Tenderness	○	Clicking/Popping Jaw	○
Loose Teeth	○	TMJ Treatment	○
Periodontal Treatment	○	Mouth Breathing	○
Broken Fillings	○	Mouth Pain	○
Food Collection in Teeth	○	Orthodontic Treatment	○
Lip or Cheek Biting	○	Sores in Mouth	○
Sensitivity to Hot/Cold	○	Other_____	

Smile Survey: If you could change anything about your smile and/or facial appearance, what would it be?
Please let us know if you are interested in learning more about these services below!

Bleaching / Teeth Whitening	YES	NO
Straighten my teeth	YES	NO
Lengthen/Shorten my teeth	YES	NO
Replace old silver fillings	YES	NO
Replace missing teeth	YES	NO
More information on Dental Implants	YES	NO
More information on Botox & Dermal Fillers	YES	NO
More information on treatment options for TMJ and Headaches	YES	NO
More information on skin rejuvenation (Hair removal, Skin lightening/brightening, Skin smoothing/tightening, fat shrinking, acne clearance)	YES	NO

Other changes you wish to make? _____
_____

Do you have any specific dental problems or areas of concern?	YES	NO
If so, Explain_____		
Do you smoke or chew tobacco?	YES	NO
Do you have a removable partial or complete denture?	YES	NO
If so, how old are they?_____		

What are your expectations from our staff and our dentist? _____
_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and the staff at the next appointment without fail.

X_____Date_____
PATIENT SIGNATURE (PARENT OR GUARDIAN)