DENTAL HISTORY

Name _____ Prefer to called _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Previous Dentist _____ How long have you been a patient? _____ Months / Years

Date of the most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) / /

I routinely see my dentist every ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) (____) _____ ❑ ❑
2. Have you had an unfavorable dental experience? _____ ❑ ❑
3. Have you ever had complications from past dental treatment? _____ ❑ ❑
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ❑ ❑
5. Do you have / have you had braces, orthodontic treatment or had your bite adjusted? _____ ❑ ❑
6. Have you ever had any teeth extracted? _____ ❑ ❑

GUM AND BONE

7. Do your gums bleed or are they painful / sensitive when brushing or flossing? _____ ❑ ❑
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ❑ ❑
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ❑ ❑
10. Is there anyone with a history of periodontal disease in your family? _____ ❑ ❑
11. Have you ever experienced gum recession? _____ ❑ ❑
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ❑ ❑
13. Have you experienced a burning sensation in your mouth recently? _____ ❑ ❑

TOOTH STRUCTURE

14. Have you had any cavities within the last 3 years? _____ ❑ ❑
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ❑ ❑
16. Do you feel or notice any holes (i.e. pitting craters) on the biting surface of your teeth? _____ ❑ ❑
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ❑ ❑
18. Do you have grooves or notches on your teeth near the gum line? _____ ❑ ❑
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ❑ ❑
20. Do you frequently get food caught between any teeth? _____ ❑ ❑

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ❑ ❑
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ❑ ❑
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ❑ ❑
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ❑ ❑
25. Are your teeth crowding or developing spaces? _____ ❑ ❑
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ ❑ ❑
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other habits? _____ ❑ ❑
28. Do you clench your teeth in the daytime or make them sore? _____ ❑ ❑
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ❑ ❑
30. Do you wear or have you ever worn a bite appliance? _____ ❑ ❑

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? _____ ❑ ❑
32. Have you ever whitened (bleached) your teeth? _____ ❑ ❑
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ❑ ❑
34. Have you been disappointed with the appearance of previous dental work? _____ ❑ ❑

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____