Dental History

Name:______________________________ Nickname:______________________________ 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?______________ Mos/Yrs

Date of most recent dental examine: _____/_____/_____ 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. Did you have braces, orthodontic treatment or had your bite adjusted?__________ ◯ ◯
6. Have you had any teeth removed?__________ ◯ ◯

GUM & BONE

7. Do your gums bleed or is it painful 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 injury) or do you have difficulty eating an apple?___ ◯ ◯
13. Have you experienced a burning sensation in your mouth?__________ ◯ ◯

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?__________ ◯ ◯
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing 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 & 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 or any other hard, dry foods?__________ ◯ ◯
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?__________ ◯ ◯
25. Are your teeth becoming more crooked, crowded, or overlapped?__________ ◯ ◯
26. Are your teeth developing spaces or becoming looser?__________ ◯ ◯
27. Do you have more than one bite and squeeze to make your teeth fit together?__________ ◯ ◯
28. Do you place your tongue between your teeth or rest your teeth against your tongue?__________ ◯ ◯
29. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?__________ ◯ ◯
30. Do you clench your teeth in the daytime or make them sore?__________ ◯ ◯
31. Do you have problems with sleep or wake up with an awareness of your teeth?__________ ◯ ◯
32. Do you wear or have you ever worn a bite appliance?__________ ◯ ◯

SMILE CHARACTERISTICS

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

Patient's Signature:______________________________ Date:__________

Doctor's Signature:______________________________ Date:__________