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? ______________Months/Years

Date of most recent dental exam ______/_______/______ Date of most recent x-rays _____/_____/_____

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 FOLLWING: **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 ever have braces, orthodontic treatment or had your bite adjusted? ______________________ □ □
6. Have you had any teeth removed or missing teeth that never developed? _________________________□ □

GUM AND BONE

7. Do your gums bleed or are they 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. Is there anyone with a history of periodontal disease in your family? ______________________________□ □
10. Have you ever experienced gum recession? ____ □ □

TOOTH STRUCTURE

11. Have you had any cavities within the past 3 years? ____ □ □
12. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
    ____ □ □
13. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?
    ____ □ □
14. Do you have grooves or notches on your teeth near the gum line? _______________________________ □ □
15. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________ □ □
16. Do you frequently get food caught between any teeth? ____ □ □

BITE AND JAW JOINT

17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
    ____ □ □
18. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____ □ □
19. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____________________ □ □
20. Are your teeth becoming more crooked, crowded or overlapped? _______________________________ □ □
21. Are your teeth developing spaces or becoming more loose? _________________________________□ □
22. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?
    ____□ □
23. Do you clench your teeth in the daytime or make them sore? _________________________________□ □
24. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ____ □ □

SMILE CHARACTERISTICS

25. Is there anything about the appearance of your teeth that you would like to change? _______________ □ □
26. Have you ever whitened (bleached) your teeth? ____ □ □
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth? ________________ □ □

Patient's Signature ____ Date ____________________

Doctor's Signature ____Date ____________________