**DENTAL HISTORY**

Name: Preferred Name: Age:

General (or previous) Dentist: Last Dental Exam:

How would you rate the condition of your mouth? ⃝ Excellent ⃝ Good ⃝ Fair ⃝ Poor

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

WHAT IS YOUR IMMEDIATE CONCERN?

**PERSONAL HISTORY** **YES NO**

Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) ⃝ ⃝

Have you had an unfavorable dental experience? ⃝ ⃝

Have you ever had complications from past dental treatment? ⃝ ⃝

Have you ever had trouble getting numb or had any bad reactions to local anesthetic? ⃝ ⃝

Did you ever have braces, orthodontic treatment or had your bite adjusted? ⃝ ⃝

Have you had any teeth removed? ⃝ ⃝

**GUM AND BONE**

Do your gums bleed or are they painful when brushing or flossing? ⃝ ⃝

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ⃝ ⃝

Have you ever noticed an unpleasant taste or odor in your mouth? ⃝ ⃝

Is there anyone with a history of periodontal disease in your family? ⃝ ⃝

Have you ever experienced gum recession? ⃝ ⃝

Have you ever had any teeth come loose on their own?(without injury) ⃝ ⃝

Have you experienced a burning sensation in your mouth? ⃝ ⃝

**TOOTH STRUCTURE**

Have you had any cavities in the past 3 years? ⃝ ⃝

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing? ⃝ ⃝

Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth? ⃝ ⃝

Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth? ⃝ ⃝

Do you have grooves or notches on your teeth near the gum line? ⃝ ⃝

Have you ever broken or chipped teeth, had a toothache or cracked filling? ⃝ ⃝

Do you frequently get food caught between any teeth? ⃝ ⃝

**BITE AND JAW JOINT**

Do you have problems with your jaw joint? (pain, sounds, locking, popping, limited opening) ⃝ ⃝

Do you feel like your lower jaw is being pushed back when you bite your teeth together? ⃝ ⃝

Do you avoid or have difficulty chewing gum, bagels, carrots, nuts, or other hard, dry foods? ⃝ ⃝

Have your teeth changed in the last 5 years, become shorter, thinner or worn? ⃝ ⃝

Are your teeth becoming more crooked, crowded or overlapped? ⃝ ⃝

Are your teeth developing spaces or becoming looser? ⃝ ⃝

Do you have more than 1 bite, squeeze, or shift your jaw to make your teeth fit together? ⃝ ⃝

Do you place your tongue between your teeth or rest your tongue against your teeth? ⃝ ⃝

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ⃝ ⃝

Do you clench your teeth in the daytime or make them sore? ⃝ ⃝

Do you have any sleep problems, wake up with a headache or an awareness of your teeth? ⃝ ⃝

Do you wear, or have you ever worn a bite appliance? ⃝ ⃝

**SMILE CHARACTERISITICS**

Is there anything about the appearance of your teeth that you would like to change? ⃝ ⃝

Have you ever whitened (bleached) your teeth? ⃝ ⃝

Have you felt uncomfortable or self-conscious about the appearance of your teeth? ⃝ ⃝

Have you been disappointed with the appearance of previous dental work? ⃝ ⃝

Patient Signature: Date:

Doctor Signature: Date: