DENTAL HISTORY

Name:_____ Preferred Name:_____ Age:_____

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:_____