

DENTAL HISTORY

Date of most recent dental exam: _____ Date of most recent x-rays: _____

Date of most recent treatment other than cleaning: _____

I routinely see my dentist every: ___3mo ___4mo ___6mo ___12mo ___Not routinely

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

Previous Dentist: _____

May we request records from your previous dentist to help us facilitate your care? ___ YES ___ NO

Please answer YES or NO to the following

YES NO

Personal History:

- | | | |
|---|-----|-----|
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ | ___ | ___ |
| 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 reactions to local anesthetic? | ___ | ___ |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? | ___ | ___ |
| 6. Have you had any teeth removed? | ___ | ___ |

Smile Characteristics:

- | | | |
|--|-----|-----|
| 7. Is there anything about the appearance of your teeth that you would like to change? | ___ | ___ |
| 8. Have you ever whitened (bleached) your teeth? | ___ | ___ |
| 9. Are you self conscious about your teeth? | ___ | ___ |
| 10. Have you been disappointed with the appearance of previous dental work? | ___ | ___ |

Bite & Jaw Joint:

- | | | |
|--|-----|-----|
| 11. Do you/would you have any problems chewing gum? | ___ | ___ |
| 12. Do you/would you have any problems chewing bagels or other hard foods? | ___ | ___ |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | ___ | ___ |
| 14. Are your teeth crowding or developing spaces? | ___ | ___ |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? | ___ | ___ |
| 16. Do you have problems with sleep or wake up with an awareness of your teeth? | ___ | ___ |
| 17. Do you have problems with your jaw joint?
(pain, sounds, limited opening, locking, popping) | ___ | ___ |
| 18. Do you have tension headaches or sore teeth? | ___ | ___ |
| 19. Do you wear or have you ever worn a bite appliance? | ___ | ___ |

Tooth Structure:

- | | | |
|---|-----|-----|
| 20. Have you had any cavities within the past 3 years? | ___ | ___ |
| 21. Do you have a dry mouth? | ___ | ___ |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? | ___ | ___ |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? | ___ | ___ |
| 24. Do you avoid brushing any part of your mouth? | ___ | ___ |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth? | ___ | ___ |

Gum & Bone

- | | | |
|--|-----|-----|
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? | ___ | ___ |
| 27. Have you ever experienced gum recession? | ___ | ___ |
| 28. Is there anyone with a history of periodontal disease in your family? | ___ | ___ |
| 29. Do your gums bleed when brushing, flossing or eating? | ___ | ___ |
| 30. Are your teeth becoming loose? | ___ | ___ |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth? | ___ | ___ |
| 32. Have you experienced a burning sensation in your mouth? | ___ | ___ |

Patient Signature (or responsible party): _____ Date: _____