DENTAL HISTORY

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we are happy to help.

Name ______________________ Nickname ______________ Birthdate __________

Referred by ____

Previous Dentist ______________________ How long were you a patient there? __________

Reason for change ____

Date of most recent exam ________ Date of most recent x-rays ________ Date of most recent treatment (other than cleaning) ________

I routinely see my dentist every _____ months   Not routinely

What is your immediate concern? ____

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

Please answer YES or NO to the following:

		Yes	No
	PERSONAL HISTORY		
1.	Are you fearful of dental treatment?		
	If so, how fearful, on a scale of 1 (least) to 10 (most): _______		
2.	Have you had an unfavorable dental experience?		
3.	Have you had complications from past dental treatment?		
4.	Do you have trouble getting numb or had reactions to local anesthetic?		
5.	Ever had braces, orthodontic treatment, bite adjustments?		
	If so, at what age? _______		
6.	Have you had teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		
	GUM AND BONE		
7.	Do your gums bleed or do you experience pain when brushing/flossing?		
8.	Have you been treated for gum disease or been told you have lost bone around your teeth?		
9.	Do you notice an unpleasant taste or odor in your mouth?		
10.	Is there a history of periodontal disease in your family?		
11.	Have you experienced gum recession?		
12.	Have you ever had teeth become loose on their own (without an injury)?		
	Do you have difficulty eating? (an apple, for example)		
13.	Have you experienced burning or painful sensations in your mouth not related to your teeth?		
	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 any food?		
16.	Do you feel or notice any holes (pitting, crates, etc) on the biting surface of your teeth?		

		Yes	No
17.	Are any teeth sensitive to hot, cold, biting, sweets?		
	Do you 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 your teeth?		
	BITE AND JAW JOINT		
21.	Do you have problems with your jaw joint? (pain, unusual sounds, limited opening, locking, popping)		
22.	Do you feel like your lower jaw is being pushed back when you bite your back teeth together?		
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars or other hard, dry foods?		
24.	In the past 5 years, have your teeth changed (become shorter, thinner or worn), or has your bite changed?		
25.	Are your teeth becoming more crooked, crowded or overlapped?		
26.	Are your teeth developing spaces or becoming looser?		
27.	Do you have trouble finding your bite - need to squeeze/tap your teeth together, shift your jaw to make your teeth fit together?		
28.	Do you place your tongue between your teeth or close 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 or grind your teeth together?		
31.	Do you have any problems with sleep (restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		
32.	Do you wear or have your ever worn a bite appliance?		

Continued

		Yes	No
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your teeth that you would like to change? (shape, color, size) If yes, ____________________		
34.	Have you ever whitened (bleached) your teeth?		
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?		
36.	Have you been disappointed with the appearance of previous dental work?		

Thank you for taking time to fill out this form to help us get acquainted and provide you with quality dental care.

Patient's Signature: ______________________________ Date: ______________

Doctor's Signature: ______________________________ Date: ______________