



DENTAL HISTORY

Patient 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 ___/___/___

Date of most recent treatment (other than a cleaning) ___/___/___

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 FOLLOWING:

PERSONAL HISTORY

YES NO

- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
- Have you had an unfavorable dental experience? _____ YES NO
- Have you ever had complications from past dental treatment? _____ YES NO
- Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ YES NO
- Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ YES NO

GUM AND BONE

YES NO

- Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____ YES NO
- Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing? _____ YES NO
- Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
- Is there anyone with a history of periodontal disease in your family? _____ YES NO
- Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ YES NO
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
- Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ YES NO

TOOTH STRUCTURE

YES NO

- Have you had any cavities within the past 3 years? _____ YES NO
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ YES NO
- Do you have grooves or notches on your teeth near the gum line? _____ YES NO
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
- Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT

YES NO

- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
- Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____ YES NO
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
- In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ YES NO
- Are your teeth becoming more crooked, crowded, or overlapped? _____ YES NO
- Are your teeth developing spaces or becoming more loose? _____ YES NO
- Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ YES NO
- Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES NO
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
- Do you clench or grind your teeth together in the daytime or make them sore? _____ YES NO
- Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ YES NO
- Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS

YES NO

- Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____ YES NO
- Have you ever bleached (whitened) your teeth? _____ YES NO
- Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ YES NO
- Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____