DENTAL HISTORY

First Name: Last Name: Date of Birth:

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

Previous Dentist Name/Office Name:

How long have you been a patient there?:

Date of most recent dental exam: Date of most recent x-ray:

Date of most recent treatment (other than a cleaning):

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

What is your IMMEDIATE conern?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES - NO Personal History

1. Are you fearful of dental treatment? How fearful, on a scale from 1 to 10:
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 had any reactions to local anesthetics?.............
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?.........................
6. Have you had any teeth removed?..

YES - NO 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. Have you felt uncomfortable or self conscious about the appearance of your teeth?............
10. Have you been disappointed with the appearance of previous dental work?.........................

YES - NO Bite and Jaw Joint

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
12. Do you/would you have any problems chewing gum?...
13. Do you/would you have any problems chewing bagels, protein bars or hard foods?.............
14. Have your teeth changed in the last 5 years, becoming shorter, thinner or worn?................
15. Are your teeth crowding or developing spaces?..
16. Do you have more than one bite and squeeze to make your teeth fit together?...................
17. Do you chew ice, bit your nails, use your teeth to hold objects, or any other oral habits?.....
18. Do you clench your teeth in the daytime or make them sore?...
19. Do you have any problems with sleep or wake up with an awareness of your teeth?...........
20. Do you wear or have you ever worn a bite appliance?..

YES - NO Tooth Structure

21. Have you had cavities with the past 3 years?..
22. Does the amount of saliva in your mouth seem too little?...
23. Do you have difficulty swallowing any food?..
24. Teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?........
25. Do you have grooves or notches on your teeth near the gum line?.......................................
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?.............
27. Do you get food caught between any teeth?..

YES - NO Gum and Bone

28. Do your gum bleed when brushing or flossing?..
29. Have you been treated for gum disease or been told you have lost bone around teeth?......
30. Have you ever noticed an unpleasant taste or odor in your mouth?......................................
31. Is there anyone with a history of periodontal disease in your family?...................................
32. Have you ever experienced gum recession?..
33. Have you ever had any teeth become loose on their own? Difficulty eating apples?............
34. Have you ever experienced a burning sensation in your mouth?...

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is the patient's responsibility to inform the dental office of any changes in medical status.

Patient Signature: Date: