SMILE Wellness Co

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 were you a patient? _____ Months/Years

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 □ 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
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	□ □
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 anesthetic? _____	□ □
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	□ □
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	□ □
GUM AND BONE	**YES/NO**
7. Do your gums bleed sometimes or are they painful when brushing or flossing? _____	□ □
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	□ □
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	□ □
10. Is there anyone with a history of periodontal disease in your family? _____	□ □
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	□ □
12. Have you ever had any teeth become loose on their own (without and injury), or do you have difficulty eating an apple? _____	□ □
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	□ □
TOOTH STRUCTURE	**YES/NO**
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 (i.e. pitting, craters) on the biting surface of your teeth? _____	□ □
17. Are any teeth sensitive to hot, cold, biting, sweets, or 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 any teeth? _____	□ □
BITE AND JAW JOINT	**YES/NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	□ □
22. Do you feel like your lower jaw is being pushed back when you try to bite (squeeze) 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 loose? _____	□ □
27. 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? _____	□ □
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 in the daytime or make them sore? _____	□ □
31. Do you have any problems with sleep (i.e. restless or teeth grinding), wake up with a headache or an awareness of your teeth? _____	□ □
32. Do you wear, or have you ever worn a bite appliance? _____	□ □
SMILE CHARACTERISTICS	**YES/NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	□ □
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? _____	□ □

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____