

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

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? _____

YES NO

GUM AND BONE

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____
 8. Have you ever been treated for gum disease, had scaling and root planing, 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 an 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? _____

YES NO

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 (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? _____

YES NO

BITE AND JAW JOINT

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 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 more 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. restlessness 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? _____

YES NO

SMILE CHARACTERISTICS

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 bleached (whitened) 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? _____

YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____