

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 _____