DENTAL HISTORY

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:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
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 reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6.	Have you had any teeth removed? _____	☐	☐
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.	Are you self conscious about your teeth? _____	☐	☐
10	Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT			
11.	Do you / would you have any problems chewing gum? _____	☐	☐
12.	Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14.	Are your teeth crowding or developing spaces? _____	☐	☐
15.	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	☐	☐
16.	Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
17.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18.	Do you have tension headaches or sore teeth? _____	☐	☐
19.	Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE			
20.	Have you had any cavities within the past 3 years? _____	☐	☐
21.	Do you have a dry mouth? _____	☐	☐
22.	Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23.	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24.	Do you avoid brushing any part of your mouth? _____	☐	☐
25.	Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE			
26.	Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27.	Have you ever experienced gum recession? _____	☐	☐
28.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29.	Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30.	Are your teeth becoming loose? _____	☐	☐
31.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32.	Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____