

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) _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
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? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Are you self conscious about your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT ● ● ●

11. Do you / would you have any problems chewing gum? _____ YES NO
12. Do you / would you have any problems chewing bagels or other hard foods? _____ YES NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
14. Are your teeth crowding or developing spaces? _____ YES NO
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ YES NO
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
18. Do you have tension headaches or sore teeth? _____ YES NO
19. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE ● ● ●

20. Have you had any cavities within the past 3 years? _____ YES NO
21. Do you have a dry mouth? _____ YES NO
22. Are any teeth sensitive to hot, cold, biting or sweets? _____ YES NO
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ YES NO
24. Do you avoid brushing any part of your mouth? _____ YES NO
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ YES NO

GUM AND BONE ● ● ●

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ YES NO
27. Have you ever experienced gum recession? _____ YES NO
28. Is there anyone with a history of periodontal disease in your family? _____ YES NO
29. Do your gums bleed when brushing, flossing or eating? _____ YES NO
30. Are your teeth becoming loose? _____ YES NO
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
32. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____