DENTAL HISTORY

Name ________________________ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist ________________________________ How long were you a patient? _______________ Months/Years
Approximate date of most recent exam ___________________ Approximate date of most recent x-rays _______________
Approximate date of most recent treatment (other than a cleaning) ____________________
Date of last Medical Exam ____________________________

WHAT IS YOUR IMMEDIATE CONCERN? ____

Please answer YES or NO to the following:

PERSONAL HISTORY

1. Are you fearful of dental treatment? ______________________________ 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 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 with 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

GUM AND BONE

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

Patient's Signature ____ Date __________________