DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
Previous Dentist _____ How long had 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 CIRCLE YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very)_____ Y N
2. Have you had an unfavorable dental experience? _____ Y N
3. Have you ever had complications from past dental treatment? _____ Y N
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ Y N
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ Y N
6. Have you had any teeth removed? _____ Y N

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ Y N
8. Have you ever whitened (bleached) your teeth? _____ Y N
9. Are you self conscious about your teeth? _____ Y N
10. Have you been disappointed with the appearance of previous dental work? _____ Y N

BITE AND JAW JOINT

11. Do you have any problems chewing gum? _____ Y N
12. Do you have any problems chewing bagels or other hard foods? _____ Y N
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ Y N
14. Are your teeth crowding or developing spaces? _____ Y N
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ Y N
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ Y N
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ Y N
18. Do you have tension headaches or sore teeth? _____ Y N
19. Do you wear or have you ever worn a bite appliance? _____ Y N

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ Y N
21. Do you have a dry mouth? _____ Y N
22. Are any teeth sensitive to hot, cold, biting or sweets? _____ Y N
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ Y N
24. Do you avoid brushing any part of your mouth? _____ Y N
25. Do you feel or notice any holes (i. e. pitting) in your teeth? _____ Y N

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ Y N
27. Have you ever experienced gum recession? _____ Y N
28. Is there anyone with a history of periodontal disease in your family? _____ Y N
29. Do your gums bleed when brushing, flossing or eating? _____ Y N
30. Are your teeth becoming loose? _____ Y N
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ Y N
32. Have you experienced a burning sensation in your mouth? _____ Y N

Patient's Signature _____ Date _____

Doctor's Signature_____ Date _____

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