DENTAL HISTORY

Last Name:	First Name:	MI:	Nickname:
Referred By:			

How would you rate the condition of your mouth?	Excellent	Good	Fair	Poor

Previous Dentist:	How long were you a patient:
Date of most recent exam:	Date of most recent X-Rays:
Date of most recent treatment (Other than a cleaning):	

I routinely see my dentist every:	3 Months	4 Months	6 Months	12 Months		
What is your immediate concern:						

PLEASE ANSWER YES OR NO TO THE FOLLOWING:		
PERSONAL HISTORY:	**YES**	**NO**
Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (Most) _____		
Have you had an unfavorable dental experience?		
Have you ever had complications from past dental treatment?		
Have you ever had trouble getting numb or had any reactions to local anesthetic?		
Did you ever have braces, orthodontics trteatment or had your bite adjusted?		
Have you had any teeth removed?		
SMILE CHARACTERISTICS:		
Is there anything about the appearance of your teeth that you would like to change?		
Have you ever whitened (bleached) your teeth?		
Have you felt uncomfortable or self conscious about the appearance of your teeth?		
Have you been disappointed with the appearance of previous dental work?		
BITE AND JAW JOINT:		
Do you have problems with your jaw joint? (pain,sounds,limited opening,locking,popping)		
Do you/would you have any problems chewing gum?		
Do you/would you have any problems chewing bagels,baguettes,protein bars or other hard foods?		
Have your teeth changed in the last 5 years,becomeshorter,thinner or worn?		
Are your teeth crowding or developing spaces?		
Do you have more than one bite and squeeze to make your teeth fit together?		
Do you chew ice,bite your nails,use your teeth to hold objects or have any other oral habits?		
Do you clench your teeth in the daytime or make them sore?		
Do you have any problems with sleep or wake up with an awareness of your teeth?		
Do you wear or have worn a bite applicance?		
TOOTH STRUCTURE:		
Have you had any cavities within the past 3 years?		
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?		
Do you feel or notice any holes (i.e. pitting, craters)on the biting surface of your teeth?		
Are any teeth sensitive to hot,cold,biting,sweets or avoid brushing any part of your mouth?		
Do you have grooves or notches on your teeth near the gum line?		
Have you ever broken teeth,chipped teeth or had a toothache or cracked filling?		
Do you get food caught between any teeth?		
GUM AND BONE:		
Do your gums bleed when brushing or flossing?		
Have you ever been treated for gum disease or been told you have lost bone around your teeth?		
Have you ever noticed an unpleasant taste or odor in your mouth?		
Is there anyonewith a history or periodontal disease in your family?		

DENTAL HISTORY

Have you ever experienced gum recession?		
Have you ever had any teeth become loose (non-injury), do you have difficulty eating an apple?		
Have you expereinced a burning sensation in your mouth?		
ANY OTHER INFORMATION RELEVANT TO YOUR DENTAL CARE NOT LISTED ABOVE?		
Signature_____ Date _____		