DENTAL HISTORY

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 CHECK THE BOX TO ALL THAT APPLY:

PERSONAL HISTORY

1. Fearful of dental treatment. Scale of 1 to 10 (very) ❑
2. Had an unfavorable dental experience ❑
3. Had complications from past dental treatments ❑
4. Had trouble getting numb or reactions to local anesthetic ❑
5. Had braces, orthodontic treatment or had bite adjusted ❑
6. Had any teeth removed ❑

SMILE CHARACTERISTICS

7. Would like to change the appearance of teeth ❑
8. Have whitened (bleached) teeth previously ❑
9. Self conscious about teeth ❑
10. Been disappointed with the appearance of previous dental work ❑

BITE AND JAW JOINT

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

TOOTH STRUCTURE

20. Had cavities within the past 3 years ❑
21. Dry mouth ❑
22. Teeth are sensitive to hot, cold, biting or sweets ❑
23. Had a toothache, cracked filling, broken, chipped or cracked tooth ❑
24. Avoid brushing certain parts of mouth ❑
25. Feel or notice any holes (i.e. pitting) in teeth ❑

GUM AND BONE

26. Been diagnosed or treated for periodontal (gum) disease ❑
27. Experienced gum recession ❑
28. History of periodontal disease in family ❑
29. Gums that bleed when brushing, flossing or eating ❑
30. Teeth are becoming loose ❑
31. Noticed an unpleasant taste or odor in mouth ❑
32. Experienced a burning sensation in mouth ❑

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____