DENTAL HISTORY

Name ________________________________ Referred by_____________________________
Previous Dentist________________________ How long were you a patient? __________(months/years)
Date of most recent dental exam ___________ Date of most recent x-rays____________
I routinely see my dentist every ____________ (months/years)
How would you rate the condition of your mouth? (circle one) ....Excellent Good Fair Poor

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE CIRCLE YES or NO TO THE FOLLOWING:

PERSONAL HISTORY

- Are you fearful of dental treatment? .... **Y N**
  How fearful on a scale of 1 (least) to 10 (most)? ___________
- Have you ever had complications from past dental treatments? .... **Y N**
- Have you ever had trouble with local anesthesia?.. **Y N**
- Did you ever have braces, orthodontic treatment or your bite adjusted?................................ **Y N**
- Have you had any teeth removed?... **Y N**
  If yes, are you interested in replacing your missing teeth?... **Y N**

SMILE AND BITE CHARACTERISTICS

- Is there anything about the appearance of your teeth that you would like to change?..................... **Y N**
- Have you ever whitened (bleached) your teeth? .... **Y N**
- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) .... **Y N**
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? .... **Y N**
- Are your teeth crowding or developing spaces? .... **Y N**
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? .... **Y N**
- Do you clench your teeth in the daytime or make them sore?.. **Y N**
- Do you have any problems with sleep or wake up with an awareness of your teeth? .... **Y N**
- Do you wear or have you ever worn a bite appliance? .... **Y N**

TEETH AND GUMS

- Have you had any cavities within the past 3 years? .... **Y N**
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?............ **Y N**
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?......... **Y N**
- Do you have grooves or notches on your teeth near the gum line?.. **Y N**
- Have you ever broken teeth, chipped teeth, had a toothache or cracked filling?................................ **Y N**
- Do you get food caught between any teeth? .... **Y N**
- Do your gums bleed when brushing or flossing?.. **Y N**
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? .... **Y N**
- Have you ever noticed an unpleasant taste or odor in your mouth?.. **Y N**
- Have you experienced gum recession?.. **Y N**

Patient's signature____**Date**______________________