

Dental History

First Name	Last Name	Preferred Name
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Date of Birth	Whom may we thank for referring you?	How would you rate the condition of your mouth?
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Name of 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
-	-	-
What is your immediate concern?		
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PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment?	How fearful, on a scale of 1 (least) to 10 (most)	2. Have you had an unfavorable dental experience?
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3. Have you ever had complications from past dental treatment?	4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	5. Did you ever have braces, orthodontic treatment or had your bite adjusted?
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At what age?	6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	
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GUM AND BONE

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	9. Have you ever noticed an unpleasant taste or odor in your mouth?
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10. Is there anyone with a history of periodontal disease in your family?	11. Have you ever experienced gum recession?	12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
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13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		
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TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?	15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
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17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?

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20. Do you frequently get food caught between any teeth?

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BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).

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24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?

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27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?

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30. Do you clench or grind your teeth together in the daytime or make them sore?

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18. Do you have grooves or notches on your teeth near the gum line?

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22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?

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25. Are your teeth becoming more crooked, crowded, or overlapped?

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28. Do you place your tongue between your teeth or close your teeth against your tongue?

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31. Do you have any problems with sleep (i.e. snoring, restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?

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19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?

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23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?

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26. Are your teeth developing spaces or becoming more loose?

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29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?

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32. Do you wear or have you ever worn a bite appliance?

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SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?

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36. Have you been disappointed with the appearance of previous dental work?

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34. Have you ever bleached (whitened) your teeth?

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35. Have you felt uncomfortable or self conscious about the appearance of your teeth?

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Patient Signature (ESign)

Date :