DENTAL HISTORY

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

Previous Dentist ______________________ How long were you a patient? ______________ Months/Years

Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______

Date of most recent treatment (other than cleaning) ______/______/______

I routinely see my dentist every: ❒ 3 mo. ❒ 4 mo. ❒ 6 mo. ❒ 12 mo. ❒ not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

Question	YES	NO
1. Are you fearful of dental treatment? Scale of 1 to 10 (very)	❒	❒
2. Have you ever had an unfavorable dental visit?	❒	❒
3. Do you prefer to use Nitrous Oxide with dental treatment / cleaning?	❒	❒
4. Have you ever had complications from past dental treatment?	❒	❒
5. Have you ever had trouble getting numb or reactions to local anesthetic?	❒	❒
6. Did you ever have braces, orthodontic treatment or had your bite adjusted?	❒	❒
7. Have you had any teeth removed?	❒	❒

SMILE CHARACTERISTICS

Question	YES	NO
8. Is there anything about the appearance of your teeth that you would like to change?	❒	❒

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Question	YES	NO
9. Have you ever whitened (bleached) your teeth?	❒	❒
10. Are you self-conscious about your teeth?	❒	❒
11. Have you been disappointed with the appearance of previous dental work?	❒	❒

BITE AND JAW JOINT

Question	YES	NO
12. Do you / would you have any problems chewing gum?	❒	❒
13. Do you / would you have any problems with chewing bagels or other hard food?	❒	❒
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❒	❒
15. Are your teeth crowding or developing spaces?	❒	❒
16. Do you clinch or grind your teeth?	❒	❒
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping)	❒	❒
18. Do you have tension headaches?	❒	❒
19. Do you wear or have you ever worn a bite appliance, splint or nightguard?	❒	❒

TOOTH STRUCTURE

Question	YES	NO
20. Have you had any cavities within the past 3 years?	❒	❒
21. Do you have a dry mouth?	❒	❒
22. Are any of your teeth sensitive to hot, cold, biting, or sweets?	❒	❒
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	❒	❒
24. Do you avoid brushing any part of your mouth?	❒	❒

GUM AND BONE

Question	YES	NO
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	❒	❒
26. Have you ever experienced gum recession?	❒	❒
27. Is there any one with a history of periodontal disease in your family?	❒	❒
28. Do your gums bleed when brushing, flossing or eating?	❒	❒
29. Are your teeth becoming loose?	❒	❒
30. Have you ever noticed an unpleasant taste or odor in your mouth?	❒	❒
31. Have you ever experienced a burning sensation in your mouth?	❒	❒

Patient's Signature ______________________________ **Date** ______________

Doctor's Signature ______________________________ Date ______________