DENTAL HISTORY FORM

Name:	Age:
How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	

PREVIOUS DENTIST:

How long were you a patient?:	Date of last dental exam:
Date of most recent x-rays:	Date of most recent treatment(not cleaning):
I routinely see my dentist every : ☐ 3 mo. ☐ 4 mo. ☐ 6mo. ☐12mo. ☐ Not Routinely	
What is your immediate concern?:	

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1.) Are you fearful of dental treatment? ☐ **YES** ☐ **NO**
If yes, How fearful on a scale of 1 (least) to 10 (most)?: _____

2.) Have you had an unfavorable dental experience? ☐ **YES** ☐ **NO**

3.) Have you ever had complications from past dental treatment? ☐ **YES** ☐ **NO**

4.) Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐ **YES** ☐ **NO**

5.) Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐ **YES** ☐ **NO**

GUM AND BONE

1.) Do your gums bleed or are they painful when brushing or flossing? ☐ **YES** ☐ **NO**

2.) Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐ **YES** ☐ **NO**

3.) Have you ever noticed an unpleasant taste or odor in your mouth? ☐ **YES** ☐ **NO**

4.) Is there anyone with a history of periodontal disease in your family? ☐ **YES** ☐ **NO**

5.) Have you ever experienced gum recession? ☐ **YES** ☐ **NO**

Tooth Structure

1.) Have you had any cavities within the past 3 years? ☐ **YES** ☐ **NO**

2.) Are any teeth sensitive to temperature, biting, sweets, or avoid brushing areas in your mouth? ☐ **YES** ☐ **NO**

3.) Do you feel or notice any holes on the biting surface of your teeth? ☐ **YES** ☐ **NO**

4.) Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? ☐ **YES** ☐ **NO**

5.) Do you frequently get food caught between any teeth? ☐ **YES** ☐ **NO**

BITE AND JAW JOINT

1.) Do you have problems with your jaw joint? ☐ **YES** ☐ **NO**

5.) Have your teeth changed in the last 5 years, become shorter, thinner or worn? ☐ **YES** ☐ **NO**

3.) Do you clench your teeth in the daytime or make them sore? ☐ **YES** ☐ **NO**

6.) Do you chew ice, bite your nails, use your teeth to hold objects, or have other oral habits? ☐ **YES** ☐ **NO**

4.) Do you wear or have you ever worn a bite appliance? ☐ **YES** ☐ **NO**

8.) Do you have any problems with sleep or wake up with an awareness of your teeth? ☐ **YES** ☐ **NO**

SMILE CHARACTERISTICS

1.) Is there anything about the appearance of your teeth that you would like to change? ☐ **YES** ☐ **NO**

2.) Have you been disappointed with the appearance of previous dental work? ☐ **YES** ☐ **NO**

3.) Have you ever whitened your teeth? ☐ **YES** ☐ **NO**

_____

Signature (responsible party) Date

_____

Doctors Signature Date