DENTAL HISTORY

Referred by_____ How would you rate the overall 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 THE PURPOSE OF YOUR INITIAL VISIT? _____

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

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	□	□
2. Have you ever had an unfavorable dental experience? _____	□	□
3. Have you had complications from past dental treatment? _____	□	□
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____	□	□
5. Did you ever have braces, orthodontic treatment, or your bite adjusted? _____	□	□
6. Have you had any teeth removed? _____	□	□

SMILE

7. Are you unhappy with the appearance of your teeth? _____	□	□
8. Have you ever whitened (bleached) your teeth? _____	□	□
9. Are you self-conscious about your teeth? _____	□	□
10. Have you been disappointed with the appearance of previous dental work? _____	□	□

BITE AND TMJ

11. Do you/ would you have any problems chewing gum? _____	□	□
12. Do you/ would you have any trouble chewing bagels or other hard foods? _____	□	□
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	□	□
14. Are your teeth crowding or developing spaces? _____	□	□
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	□	□
16. Do you have any problems sleeping or wake up with awareness of your teeth? _____	□	□
17. Do you have problems with your jaw joint? (clicking, popping, pain, limited opening, locking) _____	□	□
18. Do you have tension headaches or sore teeth? _____	□	□
19. Do you wear or ever have worn a bite appliance? _____	□	□

TEETH

20. Have you had any cavities within the last 3 years? _____	□	□
21. Do you experience dry mouth? _____	□	□
22. Are any 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? _____	□	□
25. Do you feel or notice any holes (pitting) in your teeth? _____	□	□

GUMS AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	□	□
27. Have you experienced gum recession? _____	□	□
28. Is there a history of periodontal disease in your family? _____	□	□
29. Do your gums bleed when brushing, flossing or eating? _____	□	□
30. Are your teeth becoming loose? _ _____	□	□
31. Have you had an unpleasant odor in your mouth _____	□	□

PATIENT'S SIGNATURE_____**DATE**_____

DOCTOR'S SIGNATURE_____**DATE**_____