



Dental History

Referred By _____

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

Previous Dentist _____

How long have you been a patient? _____

Date of most recent dental exam _____ Date of most recent x-rays _____

I routinely see my dentist every (circle one): 3 mo 4 mo 6 mo 12 mo

Please Answer Yes or No to the Following, if Yes Please Explain:

Personal History

Are you fearful of dental treatment? _____

Have you had an unfavorable dental experience? _____

Have you ever had complications from past dental treatment? _____

Have you ever had trouble getting numb or reactions to local anesthetic? _____

Did you ever have braces, orthodontic treatment or had your bite adjusted? _____

Have you had any teeth removed? _____

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? _____

Have you ever whitened (bleached) your teeth? _____

Are you self conscious about your teeth? _____

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

Bite and Jaw Joint

Do you/would you have any problems chewing gum, bagels, or other hard foods? _____

Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____

Are your teeth crowding or developing spaces? _____

Do you have any problems with your jaw joint? (pain, sounds, limited opening, clicking, popping) _____

Do you have tension headaches or sore teeth? _____

Do you wear or have you ever worn a bite appliance? _____

Tooth Structure

Have you had any cavities within the past 3 years? _____

Do you have a dry mouth? _____

Are any teeth sensitive to hot, cold, biting or sweets? _____

Do you avoid brushing any part of your mouth? _____

Gum and Bone

Have you ever been diagnosed with periodontal disease? _____

Have you ever experienced gum recession? _____

Do your gums bleed when brushing, flossing or eating? _____

Are your teeth becoming loose? _____