- Dental History -

TO HELP US PROVIDE A THOROUGH EXAM, PLEASE COMPLETE THIS TO THE BEST OF YOUR ABILITY. THANK YOU☺

On a scale of 1-10, how important is your dental health to you?_______ How would you rate your dental health(1-10)?_____

Who referred you?________________ Previous Dentist: ___________________ How long were you with your prior dentist? _____years.

Last dental exam: ________(months/years) ago. Last x-rays: ________(months/years) ago. Last treatment: ________(months/years) ago.

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ I do not go routinely

WHAT IS YOUR IMMEDIATE OR MAIN CONCERN TODAY?______________________________

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING. ***HELPFUL COMMENTS ARE ENCOURAGED FOR THE "YES" ANSWERS:***

PERSONAL HISTORY Risk: Low o Mod o High o	**YES**	**NO**
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10(most)__________	☐	☐
Have you ever had complications or an unfavorable dental experience? __________	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic? __________	☐	☐
Have you had any teeth removed? __________	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted? __________	☐	☐
On a scale 1-10, what is the current level of stress in your life? __________		

GUM AND BONE Risk: Low o Mod o High o	**YES**	**NO**
Have you ever been treated for gum disease or been told you have lost bone around your teeth?__________	☐	☐
Have you ever experienced gum recession (gums shrinking around teeth)? __________	☐	☐
Have you ever had any teeth become loose on their own (without an injury)? __________	☐	☐
Is there anyone in your family with a history of periodontal gum disease? __________	☐	☐
Do your gums bleed or are they painful when brushing, flossing or eating? __________	☐	☐
Do you have difficulty eating an apple due to loose teeth? __________	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth? __________	☐	☐
Have you ever or currently smoke tobacco? (circle one)__________	☐	☐
Have you experienced a burning sensation in your mouth? __________	☐	☐

TOOTH STRUCTURE Risk: Low o Mod o High o	**YES**	**NO**
Do your parents or siblings have "bad teeth"? __________	☐	☐
Have you had any cavities within the past 3 years? __________	☐	☐
Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing any food?________	☐	☐
Are any teeth currently sensitive to hot, cold, biting or sweets or do you avoid brushing any sensitive teeth?__________	☐	☐
Do you frequently snack on high sugar food/drinks throughout the day (soda, candy, cookies)? __________	☐	☐
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? __________	☐	☐
Do you frequently get food caught between specific teeth and find it to be nuisance or problematic? __________	☐	☐
Do you have grooves or notches on your teeth near the gum line? __________	☐	☐
Have you ever had a habit of sucking on lemons or eating a lot of citrus? __________	☐	☐
Do you drink high acidic beverages-on a daily basis (coffee, tea, lemonade, orange juice, soda, wine, power drinks)? _______	☐	☐
Have you ever experienced gastric acid reflux (acid coming up from stomach into your mouth, sour taste)? __________	☐	☐
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? __________	☐	☐

BITE AND JAW JOINT Risk: Low o Mod o High o	**YES**	**NO**
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? __________	☐	☐
Do you feel like your lower jaw is being pushed back when you bite your teeth together? __________	☐	☐
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars or other hard foods, dry foods? ___	☐	☐
Have your teeth changed in the last 5 years, such as become shorter, chip, thin out or worn? __________	☐	☐
Are your teeth becoming more crooked, crowded or overlapped? __________	☐	☐
Are your teeth developing spaces or becoming loose? __________	☐	☐
Do you have more than one bite, squeeze or shift to make your teeth fit together? __________	☐	☐
When bringing your teeth together, do you find that you have to search for a comfortable bite? __________	☐	☐
Do you place your tongue between your teeth or close your teeth against your tongue? __________	☐	☐
Do you have pain or soreness in the muscles of your face? Where? When? __________	☐	☐
Do you chew ice, bite your nails, or use your teeth to hold objects or have any abnormal oral habits? __________	☐	☐
Do you clench your teeth in the daytime or make them sore? __________	☐	☐
Do you grind your teeth? __________	☐	☐
Do you have problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? __________	☐	☐
Do you or have your ever worn a bite appliance (Niteguard, Splint) ? __________	☐	☐

SMILE CHARACTERISTICS Risk: Low o Mod o High o	**YES**	**NO**
What is the most important thing to you about your smile? __________		
Have you been disappointed with the appearance of previous dental work? __________	☐	☐
Have you ever bleached (whitened) your teeth? __________	☐	☐
Have you felt unhappy, uncomfortable or self-conscious about the appearance of your teeth? __________	☐	☐
Is there anything about the appearance of your teeth that you would like to change? What? __________	☐	☐
Would you like to address any of your cosmetic concerns at this time? (Is the timing good?) __________	☐	☐

Patients Name: ______________________ **Patients Signature:** ____________________ **Date:** ____________________

Doctor's Signature: ______________________________ **Date:** ____________________