DENTAL HISTORY

Patient Name_____ 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 YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWSER 'YES' OR 'NO' TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Have you had any teeth removed?	☐	☐
2. Have you ever had reactions to local anesthetic or trouble getting numb?	☐	☐
3. Have you had an unfavorable dental experience?	☐	☐
4. Are you fearful of dental treatment? Scale of 1 to 10 (very)	☐	☐
SMILE CHARACTERISTICS		
5. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
6. Would you like to discuss whitening options with the dentist?	☐	☐
7. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
8. Do you have any dental concerns that prevent you from chewing foods?	☐	☐
9. Are your teeth crowding or developing spaces?	☐	☐
10. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐	☐
11. Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
12. Have you had any cavities within the past 3 years?	☐	☐
13. Do you have a dry mouth?	☐	☐
14. Are any teeth sensitive to hot, cold, biting, or sweets?	☐	☐
15. Have you ever had a toothache, cracked filling; broken, chipped, or cracked tooth?	☐	☐
16. Do you avoid brushing any part of your mouth	☐	☐
17. Do you feel or notice any holes (i.e. pitting) in your teeth?	☐	☐
GUM AND BONE		
18. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
19. Do your gums bleed when brushing, flossing, or eating?	☐	☐
20. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐

Patient's Signature_____ **Date**_____

Doctor's Signature_____ **Date**_____