



DENTAL HISTORY

| DOB:

General Information

| | |
|--|--|
| Who was your previous Dentist and how long were you a patient there? | |
| Date of your last dental exam | |
| Date of your last cleaning | |
| Do you have any immediate concerns you'd like us to address? | |

Office Relationship

| | |
|--|--|
| What do you value most in your dental visits? | |
| Is there anything you prefer during your visits to make you more comfortable during your time with us? | |
| On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment? | |

Personal History

| | |
|--|--|
| Please answer the following questions | |
| Are you concerned about the appearance of your teeth? | |
| Are you interested in improving your smile? | |
| Have you had any cavities within the past 2 years? | |
| Are any teeth currently sensitive to biting, sweets, hot, or cold? | |
| Do you avoid or have difficulty chewing or biting heavily any hard foods? | |
| Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? | |
| Do you clench your teeth in the daytime? | |
| Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea? | |
| Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits? | |
| Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often? | |
| Have you ever noticed a consistently unpleasant taste or odor in your mouth? | |

Dental Structural History

| | |
|---|--|
| Please answer the following questions | |
| Do your gums bleed when brushing or flossing? | |
| Is brushing or flossing typically painful? | |
| Have you ever experienced or been told you have gum recession? | |
| Have you ever been treated for or been told you have gum disease? | |
| Have you had any teeth removed for braces or otherwise? | |
| Do you know of any missing teeth or teeth that have never developed? | |
| Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" | |

| | |
|--|--|
| Are your teeth becoming more crowded, overlapped, or "crooked?" | |
| Are your teeth developing spaces? | |
| Do you frequently get food caught between any teeth? | |
| Have you noticed your teeth becoming shorter, thinner, or flatter over the years? | |
| Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?) | |
| Is it often difficult to open wide? | |
| Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together? | |

Patient's signature:

Date:

Doctor's signature:

Date: