

Dental History

Patient Name: _____

Reason for today's visit: _____

How often do you routinely see the dentist? 3 months 4 months 6 months Not routinely

Please rate your anxiety/fear of dental treatment: 0 1-3 4-6 7-9 10 (or more)

How you had an unfavorable dental experience? Yes No

Ever had complications with past dental treatment? Yes No

Ever had trouble getting numb or had any reaction to anesthetic? Yes No

Do you have an immediate dental concern? Yes No If yes: _____

Bite and Jaw Joint

Do you have any problems with your jaw joint? Yes No
(Pain, sounds, limited opening, locking, popping)

Do you have any problems chewing bagels, protein bars, or other hard foods? Yes No

Have your teeth changed in the last 5 years, become shorter, thinner, or worn out? Yes No

Are your teeth crowding or developing spaces? Yes No

Do you have more than one bite and squeeze to make your teeth fit together? Yes No

Do you have any problems with sleep, or wake up with an awareness of your teeth or jaw? Yes No

Have you ever worn a bite appliance? Yes No

Tooth Structure

Have you had any cavities in the last 3 years? Yes No

Does your mouth feel dry or do you have difficulty swallowing food? Yes No

Do you feel or notice any holes, pits, or craters in your teeth? Yes No

Are your teeth sensitive to hot, cold, biting, or sweets? Yes No

Do you avoid brushing any part of your mouth? Yes No

Do you have grooves or notches on your teeth near the gum line? Yes No

Do you frequently get food caught between your teeth? Yes No

Gum and Bone

Do your gums bleed or are they painful when you brush or floss? Yes No

Have you ever been treated for gum disease or told you have lost bone? Yes No

Have you ever noticed an unpleasant taste or odor in your mouth? Yes No

Is there anyone in your family with a history of periodontal disease? Yes No

Have you ever experienced gum recession? Yes No

Have you ever had teeth become loose (without injury) or have difficulty eating? Yes No

Have you ever had a burning sensation in your mouth? Yes No

Smile Characteristics

Is there anything about the appearance of your teeth you would like to change? Yes No

Would you like your teeth whiter? Yes No

Have you felt uncomfortable or self-conscious about the appearance of your teeth? Yes No

Have you been disappointed with the appearance of previous dental work? Yes No

Signature of Patient or Guardian: _____ Date: _____