



# DENTAL HISTORY

| DOB:

## General Information

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| 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

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| 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

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| <b>Please answer the following questions</b>   |  |
| 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

|   |  |
|---|--|
| <b>Please answer the following questions</b>  |  |
| 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?" |  |

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| 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: