DENTAL HISTORY

Referred by________________ How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Previous Dentist______________________________ How long have you been a patient?_______Months/Years
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 ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

Personal History

		YES	NO
1.	Are you fearful of dental treatment? Scale of 1 to 10 (very) __________	❑	❑
2.	Have you had an unfavorable dental experience?	❑	❑
3.	Have you ever had complications from past dental treatment?	❑	❑
4.	Have you ever had trouble getting numb or reactions to local anesthetic?	❑	❑
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑	❑
6.	Have you had any teeth removed?	❑	❑

Smile Characteristics

		YES	NO
7.	Is there anything about the appearance of your teeth that you would like to change?	❑	❑
8.	Have you ever whitened (bleached) your teeth?	❑	❑
9.	Are you self conscious about your teeth?	❑	❑
10.	Have you been disappointed with the appearance of previous dental work?	❑	❑

Bite and Jaw Joint

		YES	NO
11.	Do you / would you have any problems chewing gum?	❑	❑
12.	Do you / would you have any problems chewing bagels or other hard foods?	❑	❑
13.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❑	❑
14.	Are your teeth crowding or developing spaces?	❑	❑
15.	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	❑	❑
16.	Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
17.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❑	❑
18.	Do you have tension headaches or sore teeth?	❑	❑
19.	Do you wear or have you ever worn a bite appliance?	❑	❑

Tooth Structure

		YES	NO
20.	Have you had any cavities within the past 3 years?	❑	❑
21.	Do you have a dry mouth?	❑	❑
22.	Are any teeth sensitive to hot, cold, biting or sweets?	❑	❑
23.	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	❑	❑
24.	Do you avoid brushing any part of your mouth?	❑	❑

Gum and Bone

		YES	NO
25.	Have you ever been diagnosed or treated for periodontal (gum) disease?	❑	❑
26.	Have you ever experienced gum recession?	❑	❑
27.	Is there anyone with a history of periodontal disease in your family?	❑	❑
28.	Do your gums bleed when brushing, flossing or eating?	❑	❑
29.	Are your teeth becoming loose?	❑	❑
30.	Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
31.	Have you experienced a burning sensation in your mouth?	❑	❑

Patient's Signature______________________________________ Date ________________

Doctor's Signature ______________________________________ Date ________________

POS® Reorder # 1115898