DENTAL HISTORY

How would you rate the condition of your mouth ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist/Clinic_____How long had you been a patient? _____Location: _____

Date of last visit _____/_____/_____ I routinely see my Dentist / Hygienist.: ☐ 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

1. Are you fearful of dental treatment? How fearful, on a scale of 1-10 (least to most) (____)_____ ☐ ☐
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 had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or your bite adjusted? _____ ☐ ☐
6. Have you had teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you been disappointed by the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

10. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
11. Do you / would you have any problems chewing gum? _____ ☐ ☐
12. Do you / would you have any problems chewing bagels, protein bars, or other hard foods?_____ ☐ ☐
13. Have your teeth changed in the past 5 years, became shorter, thinner or worn?_____ ☐ ☐
14. Are your teeth crowding or developing spaces?_____ ☐ ☐
15. Do you have more than one bite and squeeze to make your teeth fit together?_____ ☐ ☐
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____ ☐ ☐
17. Do you clench your teeth in the daytime or nighttime?_____ ☐ ☐
18. Do you have any problems with sleep or wake up with headaches? _____ ☐ ☐
19. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ ☐ ☐
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_ ☐ ☐
22. Do you feel or notice any holes on the biting surface of your teeth? _____ ☐ ☐
23. Are any teeth sensitive to hot, cold, biting, or sweets?_____ ☐ ☐
24. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
25. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
26. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

27. Do your gums bleed when brushing or flossing? _____ ☐ ☐
28. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____ ☐ ☐
29. Have you ever noticed an unpleasant taste or odor in your mouth?_____ ☐ ☐
30. Is there anyone with a history of periodontal disease in your family?_____ ☐ ☐
31. Have you ever experienced gum recession? _____ ☐ ☐
32. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ☐ ☐