DENTAL HISTORY

Name_________________________________ Nickname ___________________Age _____
Referred By ____________________________ Previous Dentist ______________________
How long were a patient there?_____________
Date of Most Recent Dental Exam ____/____/____ Date of Most Recent X-rays ____/____/____
Date of Most Recent Treatment ____/____/____Date of Most Recent Cleaning ____/____/____
How often have you visited your dentist? Not routinely ☐ 3 mos. ☐ 6 mos. ☐ 12 mos. ☐

What concerns you the most? ____

What would you like to change about your smile? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS: ***YES NO***

1. Are you fearful of dental treatment? ______________________________
2. If so, on a scale of 1 (least) to 10 (most) how fearful are you ? [ ] ______
3. Have you had an unfavorable dental experience before? _____________
4. Have you had trouble becoming numb for a dental procedure? _________
5. Have you had any braces or other orthodontic treatment? ____________
6. Have you had your bite adjusted? _____________________________
7. Are you missing any teeth or have had teeth removed? _____________

8. Have you whitened or bleached your teeth? ______________________
9. Do you feel uncomfortable about the appearance of your teeth? ________
10. Are you disappointed with any previous dental work? ______________

11. Do you have any problems with your jaw joint? ____________________
12. Do you have any problems chewing gum? _______________________
13. Do you have any problems chewing hard or tough foods?____________
14. Have your teeth changed, becoming worn, thinner, or shorter? _________
15. Are your teeth becoming crowded or have you noticed spaces? ________
16. Is your bite unstable / do you have to squeeze to make your teeth fit?____
17. Do you chew ice, pens, bite your nails, or other habits? ______________
18. Do you clench your teeth? ________________________________
19. Do you awake with your jaw muscles or your teeth feeling sore? ________
20. Have you worn a bite guard or similar appliance? ________________

21. Have you had any cavities in the past 3 years? __________________
22. Do you use toothpaste with fluoride? ________________________
23. Do you have any notches in your teeth near the gum line? ____________
24. Have you ever chipped a tooth or a filling or had a toothache? __________
25. Do you get any food caught between any of your teeth? _____________
26. Do you have any gum recession?____________________________
27. Do your gums bleed frequently or bleed when you brush or floss? _______
28. Have you had any teeth become loose? _______________________

______________________________________ ____________
Patient Signature Date

______________________________________ ____________
Doctor Signature Date