DENTAL HISTORY

NAME: _____

What is the reason for your dental visit today? _____

Are you presently having a dental problem? ____yes ____no

If yes, what is the problem? _____

When was your last dental visit? _____ What was done? _____

When was your last dental hygiene visit? _____ What was done? _____

Have you ever had a complete series (16-20) of dental x-rays taken? ____yes ____no

If yes, when? _____ where? _____

Have you ever experienced any unfavorable reactions to dental treatment? ____yes ____no

If yes, please explain _____

Name of previous dentist _____ phone # _____

Reason for leaving office _____

How do you feel about your teeth? _____

How would you assess your present dental health? __excellent __good __fair __poor

*please check all that apply

Sensitivity to cold		Persistent toothaches		Food collection between teeth	
Sensitivity to heat		Swelling in mouth		Lip or cheek biting	
Sensitivity to sweets		Dry mouth		Mouth breathing	
Sensitivity when biting		Bad breath		Blisters on lips	
Broken teeth		Bad taste in mouth		Blisters in mouth	
Missing fillings		Burning sensation on tongue		Growths in mouth	

Have you ever been told you have periodontal (gum) disease? ____yes ____no

Have you received treatment? ___yes ___no

Do you see a periodontist regularly? ___yes ___no

Do your gums bleed when you brush or floss? ___yes ___no

How often do you brush? _____ floss? _____

Are your gums swollen or tender? ___yes ___no

Are your teeth loosening? ___yes ___no Have they shifted position? ___yes ___no

Have you ever received treatment for TMJ discomfort or dysfunction? ___yes ___no

Have you ever had any head, neck or jaw injuries? ___yes ___no

Have you ever experienced any of the following in your jaw?

Clicking or popping sounds? ___yes ___no

Pain around ear or side of face? ___yes ___no

Difficulty in opening or closing mouth? ___yes ___no

Difficulty or pain when chewing? ___yes ___no

Do you have frequent headaches? ___yes ___no

Are you aware of any clenching or grinding of your teeth? ___yes ___no

Have you ever been advised to wear a night guard or other appliance? ___yes ___no

Do you presently wear a night guard or other appliance? ___yes ___no

Are you satisfied with the appearance of your teeth? ___yes ___no

If no, what changes would you like to see? _____

Have you ever had orthodontic treatment? ___yes ___no if yes, when? _____

Would you like your smile to look better or different? ___yes ___no

Would you like to whiten discolored teeth? ___yes ___no

Do you wear dentures? ___yes ___no please check: full dentures ___ partial dentures ___

Are you Unhappy with your dentures? ___yes ___no

Would you like to know more about permanent replacements?

Fixed bridgework ___yes ___no Implants ___yes ___no

Does dental treatment make you nervous? ____yes ____no

If yes, check: _____slightly _____moderately _____extremely

What makes you nervous? _____

Are you interested in being sedated during treatment? ____yes ____no

Have you ever used Nitrous Oxide Analgesia? ____yes ____no

Would you be interested at this time? ____yes ____no

Please provide any other information that you think would be helpful for us to know?

_____

Signature: _____ Today's date: _____