

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**DENTAL HISTORY**

DO YOU HAVE A SPECIFIC DENTAL PROBLEM OR CONCERN TODAY?  YES  NO DESCRIBE \_\_\_\_\_

DO YOU HAVE DENTAL EXAMINATIONS ON A ROUTINE BASIS?  YES  NO LAST VISIT \_\_\_\_\_

DO YOU BELIEVE YOU HAVE ACTIVE DECAY OR GUM DISEASE?  YES  NO WHY? \_\_\_\_\_

DO YOUR GUMS EVER BLEED?  YES  NO WHEN? \_\_\_\_\_

DOES FOOD EVER CATCH BETWEEN YOUR TEETH?  YES  NO ANY LOOSE TEETH?  YES  NO WHERE? \_\_\_\_\_

DO YOU WANT TO KEEP YOUR REMAINING TEETH?  YES  NO DISCUSS \_\_\_\_\_

DO YOU EVER HAVE CLICKING, POPPING, OR DISCOMFORT IN THE JAW JOINT?  YES  NO DO YOU BRUX, CLENCH, OR GRIND YOUR TEETH?  YES  NO

DO YOU SMOKE OR CHEW?  YES  NO HOW MUCH/OFTEN? \_\_\_\_\_

ANY SORES OR GROWTHS IN YOUR MOUTH?  YES  NO DISCUSS \_\_\_\_\_

WHAT IS YOUR NORMAL DAILY ORAL HYGIENE ROUTINE? \_\_\_\_\_

WHAT PRODUCTS DO YOU USE? \_\_\_\_\_

HAVE YOU EVER WORN BRACES?  YES  NO WHEN? \_\_\_\_\_

DO DENTAL PROBLEMS SEEM TO RUN IN YOUR FAMILY?  YES  NO DISCUSS \_\_\_\_\_

HAVE YOU EVER BEEN DIAGNOSED WITH PERIODONTAL DISEASE?  YES  NO

IF SO, WHAT TREATMENT DID YOU RECEIVE? \_\_\_\_\_

ARE YOU SELF-CONSCIOUS ABOUT SMILING IN FRONT OF OTHER PEOPLE?  YES  NO

DO YOU EVER COVER YOUR MOUTH WHEN YOU SMILE?  YES  NO

DO YOU HAVE CHIPS, CRACKS, OR SPACES THAT YOU WISH WERE NOT THERE?  YES  NO

DO YOU HAVE ANY MISSING TEETH THAT HAVE NOT BEEN REPLACED?  YES  NO

ARE YOU PLEASED WITH THE COLOR OF YOUR TEETH?  YES  NO

DO YOU HAVE ONE OR TWO TEETH THAT ARE DARKER THAN THE REST OF YOUR TEETH?  YES  NO

ARE YOUR TEETH STAINED?  YES  NO

DO YOU LIKE THE SHAPE OF YOUR TEETH?  YES  NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, OR THE APPEARANCE OF YOUR TEETH, WHAT WOULD IT BE? \_\_\_\_\_

DO YOU HAVE A PROBLEM WITH SNORING?  YES  NO SLEEP APNEA?  YES  NO DAYTIME SLEEPINESS?  YES  NO

HOW OFTEN DO YOU EXPERIENCE HEADACHES, APPROXIMATELY?

ALMOST NEVER  ONE EVERY TWO TO THREE MONTHS  ONE A MONTH  ONE A WEEK  MORE THAN ONE A WEEK  ONE A DAY  MORE THAN ONE A DAY

HAVE YOUR PAST EXPERIENCES IN A DENTAL OFFICE ALWAYS BEEN POSITIVE?  YES  NO DISCUSS \_\_\_\_\_

WHEN DID YOU LAST HAVE A SET OF FULL MOUTH X-RAYS (16 SMALL FILMS OR PANORAMIC)? \_\_\_\_\_

NAME OF PREVIOUS DENTIST (OPTIONAL) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

PATIENT SIGNATURE (OR RESPONSIBLE PARTY) \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWED BY DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_