

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____
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:

PERSONAL HISTORY



YES NO

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ YES ☐ NO
2. Have you had an unfavorable dental experience? _____ ☐ YES ☐ NO
3. Have you ever had complications from past dental treatment? _____ ☐ YES ☐ NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ YES ☐ NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ ☐ YES ☐ NO
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____ ☐ YES ☐ NO

GUM AND BONE



YES NO

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____ ☐ YES ☐ NO
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____ ☐ YES ☐ NO
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____ ☐ YES ☐ NO
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ YES ☐ NO
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ ☐ YES ☐ NO
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____ ☐ YES ☐ NO
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____ ☐ YES ☐ NO

TOOTH STRUCTURE



YES NO

14. Have you had any cavities within the past 3 years? _____ ☐ YES ☐ NO
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____ ☐ YES ☐ NO
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____ ☐ YES ☐ NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ ☐ YES ☐ NO
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ YES ☐ NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ YES ☐ NO
20. Do you frequently get food caught between any teeth? _____ ☐ YES ☐ NO

BITE AND JAW JOINT



YES NO

21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? _____ ☐ YES ☐ NO
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? _____ ☐ YES ☐ NO
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ YES ☐ NO
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ ☐ YES ☐ NO
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ YES ☐ NO
26. Are your teeth developing spaces or becoming more loose? _____ ☐ YES ☐ NO
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? _____ ☐ YES ☐ NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ YES ☐ NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ YES ☐ NO
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? _____ ☐ YES ☐ NO
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ ☐ YES ☐ NO
32. Do you wear or have you ever worn a bite appliance? _____ ☐ YES ☐ NO

SMILE CHARACTERISTICS



YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? _____ ☐ YES ☐ NO
34. Have you ever bleached (whitened) your teeth? _____ ☐ YES ☐ NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ ☐ YES ☐ NO
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ YES ☐ NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____