Dental History

Name: ______________________________________ Date: __________________

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of previous dentist and how long were you a patient there? ____

Date of most recent dental exam: _______________ Date of most recent dental x-rays: _______________________

I routinely see a dentist every:

☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate dental concern? ____

Personal Dental History, Check all that apply

☐ I had trouble getting numb or reactions to local anesthetic
☐ I had other unfavorable dental experience or complications from past dental treatment (beyond anesthetic)
☐ I had orthodontic treatment

Smile Characteristics, Check all that apply

☐ I would like to change the appearance of my teeth
☐ I have whitened my teeth in the past
☐ I have been disappointed with the appearance of previous dental work

Bite and Jaw Joint, Check all that apply

☐ I have pain or discomfort in the jaw joint
☐ I have noticed wear on my teeth
☐ I have noticed crowding or spacing in my teeth
☐ I have a history or currently chew ice, bite nails, or have other habits that affect the teeth
☐ I clench my teeth during the daytime or at nighttime
☐ I have worn or currently wear a nightguard

Tooth Structure, Check all that apply

☐ I have had cavities within the last three years
☐ I have a dry mouth with limited saliva
☐ I have holes, grooves, notches, or spaces in the teeth where food gets caught

Gum and Bone, Check all that apply

☐ My gums bleed when I am brushing or flossing
☐ I have a history of periodontal diagnosis and/or treatment
☐ I am concerned about bad breath
☐ I have noticed my gums receding
☐ I have loose teeth without any injury