# 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