

DENTAL HISTORY

PATIENT NAME _____	DATE _____
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Welcome! So that we may provide you with the best possible care, please take a moment to fill out this form.

Please check Yes or No and/or complete in detail.

- | | | YES | NO |
|--|--------------------------|--------------------------|----|
| 1. Reason you made this appointment? _____ | | | |
| 2. When did you last visit the dentist? _____ | | | |
| 3. Who was your previous dentist? _____ | | | |
| 4. How often did you visit the dentist before then? _____ | | | |
| 5. Are you presently in any dental pain? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, please describe _____ | | | |
| 6. Have you ever had an unpleasant experience at the dentist? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, please describe _____ | | | |
| 7. Have you ever had: | | | |
| • orthodontic treatment? If yes, give year _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| • gum treatment? If yes, give year _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| • oral surgery? If yes, give year _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| • cosmetic dentistry? If yes, give year _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Are you interested in hearing about dental implants? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Have you ever had an injury to the head, jaws of mouth? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, describe and when _____ | | | |
| 10. Does dental treatment make you nervous? If yes <input type="checkbox"/> Moderately or <input type="checkbox"/> Extremely | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Are you deeply concerned about the finances required to attain excellent dental health? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Have you ever neglected or not shown up for dental appointments in the past? | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, explain reasons _____ | | | |

ORAL HEALTH

- | | | YES | NO |
|---|--------------------------|--------------------------|----|
| 1. How often do you brush your teeth? _____ | | | |
| 2. How often do you floss your teeth? _____ | | | |
| 3. Do you use a fluoride or other rinse? If yes, how often? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Do your gums bleed when you brush? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Do you use any other dental aids? (toothpick, electric toothbrush, etc.) If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Does food tend to become caught between your teeth? If yes, where? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |

Have you ever had the following? (check all boxes that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Unpleasant taste/bad breath | <input type="checkbox"/> Swelling/lumps in mouth | <input type="checkbox"/> Soreness in facial muscles | <input type="checkbox"/> Teeth sensitive to hot |
| <input type="checkbox"/> Burning tongue, lips | <input type="checkbox"/> Clicking/ popping jaw | <input type="checkbox"/> Headaches, neckaches | <input type="checkbox"/> Teeth sensitive to cold |
| <input type="checkbox"/> Frequent blisters or sores | <input type="checkbox"/> Difficulty opening/closing jaw | <input type="checkbox"/> Change in bite | <input type="checkbox"/> Teeth sensitive to sweets |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Clenching/grinding teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Snoring |

Please check one box below per section.

- | | |
|---|--|
| <p>I. <input type="checkbox"/> think the appearance of my mouth is excellent.</p> <p><input type="checkbox"/> think the appearance of my mouth is adequate.</p> <p><input type="checkbox"/> wish I could change the appearance of my mouth.</p> | <p>II. <input type="checkbox"/> desire EXCELLENT oral health.</p> <p><input type="checkbox"/> desire AVERAGE or GOOD oral health.</p> <p><input type="checkbox"/> desire crisis care only.</p> |
| <p>III. <input type="checkbox"/> want to save my teeth at all costs.</p> <p><input type="checkbox"/> prefer to keep my teeth if cost & time are reasonable.</p> <p><input type="checkbox"/> expect to someday loose my teeth and have dentures.</p> | <p>IV. <input type="checkbox"/> have set goals to achieve optimum oral health with a dentist.</p> <p><input type="checkbox"/> want to set goals concerning my dental health.</p> <p><input type="checkbox"/> usually only go to the dentist for problems or emergencies.</p> |

What ideally would you change about your teeth or smile? _____

Please add any comments that you feel will assist this dental team in our concern for your treatment. _____