

Dental History

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:

- Did you ever have braces, orthodontic treatment or had your bite adjusted? Yes No
- Is there anything about the appearance of your teeth that you would like to change? Yes No
- Do you/would you have any problems chewing gum? Yes No
- Do you/would you have any problems chewing bagels or other hard foods? Yes No
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? Yes No
- Are your teeth crowding or developing spaces? Yes No
- Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? Yes No
- Do you have any problems with sleep or wake up with an awareness of your teeth? Yes No
- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) Yes No
- Do you have tension headaches or sore teeth? Yes No
- Do you wear or have you ever worn a bite appliance? Yes No
- Have you ever had trouble getting numb or reactions to local anesthetic? Yes No

Please rate, in order of value, what is most important to you in your dental care:

(The most important will be #1.)

- ____ Preventive care
- ____ Only what is necessary at the time: Cost is important
- ____ Comprehensive, quality care
- ____ Other _____

Please rate, as above, what is most important to you in your relationship with a dentist:

- ____ Show me what he/she is doing or planning to do so I can clearly see what is happening.
- ____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.
- ____ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have regarding dental treatment.

(10 being the most fearful, 1 being the least amount of fear.)

1 2 3 4 5 6 7 8 9 10

Patient's signature _____ Date _____

Doctor's signature _____ Date _____