Dental History Forms (New Adults)

First Name
-

Last Name
-

Preferred Name
-

Date of Birth
-

Referred by
-

How would you rate the condition of your mouth?
-

Name of 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
-

What is your immediate concern?
-

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment?
-

How fearful, on a scale of 1 (least) to 10 (most)
-

2. Have you had an unfavorable dental experience?
-

3. Have you ever had complications from past dental treatment?
-

4. Have you ever had trouble getting numb or had any reactions to local anesthetic?
-

5. Did you ever have braces, orthodontic treatment or had your bite adjusted?
-

At what age?
-

6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?
-

GUM AND BONE

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?
-

8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?
-

9. Have you ever noticed an unpleasant taste or odor in your mouth?
-

10. Is there anyone with a history of periodontal disease in your family?
-

11. Have you ever experienced gum recession?
-

12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
-

13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?
-

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?
-

15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
-

16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
-

17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
-

18. Do you have grooves or notches on your teeth near the gum line?
-

19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
-

20. Do you frequently get food caught between any teeth?
-

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).
-

22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?
-

23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?
-

24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?
-

25. Are your teeth becoming more crooked, crowded, or overlapped?
-

26. Are your teeth developing spaces or becoming more loose?
-

27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?
-

28. Do you place your tongue between your teeth or close your teeth against your tongue?
-

29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
-

30. Do you clench or grind your teeth together in the daytime or make them sore?
-

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?
-

32. Do you wear or have you ever worn a bite appliance?
-

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?
-

34. Have you ever bleached (whitened) your teeth?
-

35. Have you felt uncomfortable or self conscious about the appearance of your teeth?
-

36. Have you been disappointed with the appearance of previous dental work?
-

Patient Signature (ESign)

Date :