Smiles for Life DENTAL CARE

Dental History

Name _____ Nickname_____ Date _____

Age _____ Referred by _____ Previous Dentist _____

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 [circle one]: 3 months, 4 months, 6 months, 12 months, Not Routinely

What is your immediate concern?

_____

_____

Please Answer Yes or No to the Following

Yes	No	
		Personal History
☐	☐	Are you fearful of dental treatment?
☐	☐	Have you had an unfavorable dental experience or complications from past dental treatment?
☐	☐	Have you ever had trouble getting numb or had any reactions to local anesthetic?
☐	☐	Did you ever have braces, orthodontic treatment, or had your bite adjusted?
☐	☐	Have you had any teeth removed or missing teeth that never developed?
		Gum and Bone
☐	☐	Do your gums bleed or are they painful when brushing or flossing?
☐	☐	Have you ever been treated for gum disease, been told you have lost bone around your teeth, or have anyone with a history of periodontal disease in your family?
☐	☐	Have you ever noticed an unpleasant taste or odor in your mouth?
☐	☐	Have you ever experienced gum recession?
☐	☐	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating hard, dry foods (apples, chewing gum, carrots, nuts, bagels, etc.)?
☐	☐	Have you experienced a burning or painful sensation in your mouth not related to your teeth?
		Tooth Structure
☐	☐	Have you had any cavities, broken or chipped teeth, grooves near the gum line, or a toothache or cracked filling?
☐	☐	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
☐	☐	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?

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Dental History

Please Answer Yes or No to the Following

Yes	No	
		Bite and Jaw Joint
☐	☐	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).
☐	☐	Do you have more than one bite, have to squeeze or shift your jaw to make your teeth fit together, or feel like your lower jaw is being pushed back when you bite?
☐	☐	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
☐	☐	Are your teeth becoming more crooked, crowded, or overlapped?
☐	☐	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
☐	☐	Do you clench your teeth in the daytime or make them sore?
☐	☐	Do you have any problems with sleep (i.e., restlessness) or wake up with a headache or an awareness of your teeth?
☐	☐	Have you ever worn a sleep device?
☐	☐	Do you wear or have you ever worn a bite appliance?
		Cavity Risk
☐	☐	Do you take medications daily? If so, how many?
☐	☐	Do you feel as though you have a dry mouth at any time of the day or night?
☐	☐	Do you drink liquids other than water more than 2 times daily between meals?
☐	☐	Do you snack daily between meals?
☐	☐	Do you notice plaque build-up on your teeth between brushings?

- If you could whiten your teeth for a cost anyone could afford, would you do it? _____
- Do you smoke or use chewing tobacco? How much? For how long? _____
- If you could change your smile, you would:
  - [ ] Make them brighter
  - [ ] Make them straighter
  - [ ] Close spaces
  - [ ] Replace black metal fillings with natural, tooth-colored fillings
  - [ ] Repair chipped teeth
  - [ ] Replace missing teeth
  - [ ] Replace old crowns that don't match
  - [ ] Have a smile makeover
- How important is your dental health to you? 1-10 _____
- Where would you rate your current dental health? 1-10 _____
- Why did you leave your previous dentist? _____
  _____
- What is the most important thing to you about your future smile and dental health? _____
  _____
- What is the most important thing to you about your dental visit today? _____
  _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____