DENTAL HISTORY:

What would you like for us to do for you?__________

When was your last visit to a dentist?__________

When were your full mouth x-rays taken? (small x-rays) __________ panoramic x-ray? (one large x-ray of jaw) __________

When was your last cleaning?__________

How often do you have cleanings? 3 months_____ 4 months_____ 6 months_____ 1 year or longer_____

Is there any condition or previous difficulty that your dentist should know about before undertaking treatment? Yes ☐ No ☐ If so, please explain:

____

Do you have any dental fears or unfavorable dental experiences that you would like to discuss? Yes ☐ No ☐ __________

Have you ever had a.) nitrous oxide (laughing gas) Yes ☐ No ☐

b.) sedatives (valium, diazepam, etc.) Yes ☐ No ☐

c.) if so, was it helpful and effective? Yes ☐ No ☐

Would you consider Nitrous Oxide Gas (laughing gas) or Sedatives (valium, diazepam, etc.) for dental treatment if possible, to help you relax? Yes ☐ No ☐

Are you nervous about today's visit? Yes ☐ No ☐

What bothers you the most about going to the Dentist?__________

Name of your previous Dentist:__________

How long were you a patient of your last Dentist?__________

What qualities do you look for or desire in your Dentist?__________

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY EXPERIENCE:

Yes No

- ☐ ☐ Have you ever had an adverse reaction to local anesthetic such as lidocaine, novocaine, etc?
- ☐ ☐ Have you ever been treated by a dental specialist; (orthodontist = braces, periodontist = gum treatment, endodontist = root canals, oral surgeon = jaw surgery or wisdom tooth extractions) please list Doctor's Name__________
- ☐ ☐ Do you avoid brushing or chewing on any part of your mouth?__________
- ☐ ☐ Have you ever had professional instructions in dental home care (tooth brushing, flossing, etc.)
- ☐ ☐ How often do you brush?__________ How often do you floss?__________
- ☐ ☐ Do you think you may have decay or gum disease?
- ☐ ☐ Have you ever been told you have gum or or periodontal disease?

Yes No

- ☐ ☐ Have you noticed any loose teeth?
- ☐ ☐ Bleeding or sore gums?
- ☐ ☐ Daily bad breath?
- ☐ ☐ Daily bad taste?
- ☐ ☐ Sensitivity to hot, cold, sweets, or air?
- ☐ ☐ Does food catch between your teeth?
- ☐ ☐ Do you want to keep your remaining teeth?
- ☐ ☐ Do you grind or clench your teeth? In the day time or while sleeping?__________
- ☐ ☐ Pain or problems while chewing
- ☐ ☐ Have you ever worn a plastic bite plate, mouthguard, or splint?
- ☐ ☐ Do you bite your lips or cheeks regularly?
- ☐ ☐ Have you noticed any change in your bite?
- ☐ ☐ Does your bite feel comfortable?
- ☐ ☐ Do you have clicking, pain, discomfort, or popping in your jaw joints?__________
- ☐ ☐ Have you ever been treated for TMJ?
- ☐ ☐ Have you ever had your bite adjusted or teeth ground?

Yes No

- ☐ ☐ Do you feel you are under a great deal of stress at this time of your life?
- ☐ ☐ Do you feel pain to any of your teeth?
- ☐ ☐ Do you breathe through your mouth while awake or asleep?
- ☐ ☐ Do you snore at night?
- ☐ ☐ Have you had any difficult extractions in the past?
- ☐ ☐ Have you ever had a 'dry socket' after an extraction?
- ☐ ☐ Have you ever had any previous serious injuries to the mouth, teeth, jaw, or head?
- ☐ ☐ Do you often experience 'dry mouth'?
- ☐ ☐ Do you have any sores or lumps in or near the mouth or head and neck area?
- ☐ ☐ Do you drink two or more soft drinks a day?
- ☐ ☐ Do you have dental implants?

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SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial dentures, please complete the following: (Please check Yes or No)

Yes No

- ☐ ☐ Have your present dentures been relined? When:__________
- ☐ ☐ Is your present denture a problem? Please describe:__________
- ☐ ☐ Satisfied with appearance?
- ☐ ☐ Satisfied with comfort?
- ☐ ☐ Satisfied with chewing ability?

When did you receive your first partial or denture?__________

How long have you worn your present denture?__________

Has dental treatment ever been suggested to you that wasn't completed? Yes ☐ No ☐

If yes, what was proposed?__________

Why did you decide to decline this treatment?__________

Dental professionals like to think that people ought to keep their natural teeth forever. Is that your expectation? Yes ☐ No ☐

Who do you feel has the ultimate responsibility for controlling disease in your mouth?__________

How would you rate your current dental health today? (using a scale 1 - 10, with 1 as the worst and 10 as the best, please circle) 1 2 3 4 5 6 7 8 9 10

If there were no obstacles, what would you like your dental health to be, using the same scale as above? (please circle) 1 2 3 4 5 6 7 8 9 10

Is there any other dental problem not listed above that you would like to discuss?__________

REFERRAL: Whom may we thank for referring you to our office?__________

Doctor's Remarks:__________

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DOCTOR'S SIGNATURE__________ DATE__________