PATIENT DENTAL HISTORY

Name _____ Referring Dentist _____ Date: _____

Circle One

Yes No Do you consider yourself in good dental health?

Yes No Do you think that your teeth or gums are affecting your health in any way?

Yes No Are you dissatisfied with the appearance of your teeth or gums?

Yes No Are you dissatisfied with your chewing ability?

Have you ever had:

_____ Orthodontic Treatment (Braces) if yes, approximately when? _____

_____ Oral Surgery (Extractions, etc.) if yes, approximately when last? _____

_____ Periodontal Treatment if yes, approximately when? _____

_____ Your teeth ground or bite adjusted

_____ A bite plate or other appliance for grinding. Do you currently use it? ☐ yes ☐ no

Yes No Have you noticed any loosening of your teeth?

Yes No Does food tend to become caught between your teeth?

Yes No Do you suffer from pain and/or swelling of your gums?

Yes No Do your gums ever bleed when you brush your teeth?

Yes No Do you have an unpleasant odor or taste in your mouth?

Yes No Are you missing any teeth? ☐ yes ☐ no

Reasons: Decay ( ) Gum Disease ( ) Other ( )

If you are missing teeth are you interested in implants as replacements? ☐ yes ☐ no ☐ maybe

Yes No Have any teeth been replaced? If yes, with bridges, implants or dentures? _____

When did you last have your teeth cleaned before this appointment? _____

How long before that? _____

How often do you see your dentist? _____

How often and when do you brush your teeth? _____

Do you use: Hand toothbrush ( ) Electric toothbrush ( )

Is your toothbrush: Soft ( ) Medium ( ) Hard ( )

What else do you use to clean your teeth? (floss, toothpick, waterpick, etc.) _____

How often? _____

Yes No Do you feel apprehensive when you are having dental treatment?

Yes No Would you like to be sedated for dental treatment?

Yes No Does the fear of pain make you postpone your dental treatment?

Yes No Is it important to you to keep your teeth?

Yes No Would you spend fifteen minutes a day in order to keep your natural teeth?