

## DENTAL HISTORY

NAME \_\_\_\_\_ Date \_\_\_\_\_

This personal information will help us determine your objectives, needs and treatment. All information is confidential. Can confidential information be shared with your spouse or family member? Yes No Another person? Yes No

Specific restrictions: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Are you aware of any particular dental problems? \_\_\_\_\_

How long has it been since you last visited a dental office? \_\_\_\_\_

What was done for you at that time? \_\_\_\_\_

Were X-rays taken? Yes No Are your X-rays available to us today? Yes No

Did you schedule regular dental visits? \_\_\_\_\_

Is there anything about your past dental experience that you would like us to know? Yes No Please describe \_\_\_\_\_

Are you apprehensive about dental treatment? Yes No If yes, what concerns you? \_\_\_\_\_

Is the water you drink mostly city bottled well home-filtered? Is your water fluoridated? Yes No Don't know

Do you drink sugared beverages? soda fruit juices sugared tea or coffee How many per day? \_\_\_\_\_

Have you had the nerves of any teeth removed (root canals)? Yes No

Are you troubled by mouth odors or bad tastes? Yes No

Does your mouth feel dry often? Yes No

Do you use a power toothbrush? Yes No Brand \_\_\_\_\_

Do you prefer a local anesthetic ("novocaine") for most dental treatment? Yes No

Do you prefer nitrous oxide ("laughing gas") for routine dental treatment? Yes No

Have you worn braces on your teeth? Yes No

During the day or night, are you aware of grinding your teeth? Yes No Clenching? Yes No

Does your jaw click or pop? Yes No

Have you experienced any pain or soreness in the muscles of your face, head or neck? Yes No

Have you ever been treated for or suspect that you have TMJ disorder? Yes No

Do you get canker or "cold sores" in your mouth or on your lips? Yes No

Have you ever smoked/chewed tobacco? Yes No When/how much? \_\_\_\_\_ Do you want to quit? Yes No

Are you satisfied with your past dentistry? Yes No

How do you feel about the condition of your mouth? (poor) 1 2 3 4 5 (great)

How would you like it to be? 1 2 3 4 5

What would make the difference? \_\_\_\_\_

How would you like your teeth to be 5 years from now? \_\_\_\_\_

What is most important to you about your teeth? \_\_\_\_\_

If you could change your smile, what would you change? \_\_\_\_\_

What is your interest in cosmetic dentistry? (low) 1 2 3 4 5 (high)

Are you interested in a complete discussion of ways to improve/change your smile? Yes No

Will you make decisions about your dental care? Yes No

Will an insurance company make decisions about your dental care? Yes No