

## DENTAL HISTORY

This personal information will help us give you the best consideration of your time, needs and treatment. All information is, of course, confidential. Can any confidential information be shared with your spouse?  Yes  No Another person?  Yes  No  
Specific restrictions: \_\_\_\_\_

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

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

Are you having any discomfort or pain? \_\_\_\_\_

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

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

How many X-rays were taken, if any? \_\_\_\_\_ Do you know what type? \_\_\_\_\_

Are your X-rays available to us? \_\_\_\_\_ Today? \_\_\_\_\_

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

Is there anything about having dental treatment that you would like us to know?  Yes  No

If yes, please describe \_\_\_\_\_

Have you ever responded adversely to dental treatment?  Yes  No If so, please describe \_\_\_\_\_

Are you apprehensive about dental treatment?  Yes  No If yes, what is your greatest concern? \_\_\_\_\_

Have you had any unpleasant dental experiences? Y N If so, please describe \_\_\_\_\_

What can we do to make your visit most comfortable? \_\_\_\_\_

Do you have fluoride in your tap water?  Yes  No  Don't know

Do you drink predominately  city  bottled  well  home filtered water?

Do you drink sugared beverages?  soda  fruit juices  sugared tea or coffee

If yes, how much per day? \_\_\_\_\_

Have you had the nerves of any teeth removed? Y N

Are you troubled by mouth odors or bad tastes? Y N

When and how often do you brush your teeth? \_\_\_\_\_

Do you use a power toothbrush? Y N Brand? \_\_\_\_\_

Would you prefer a local anesthetic "novocaine" for most dental treatment? Y N

Have you had nitrous oxide "laughing" gas? Y N

Have you worn braces on your teeth? Y N

Have you ever been treated for or suspect that you have TMJ disorder? Y N

Do you grind or clench your teeth during the day or night? Y N

Does your jaw click or pop? Y N

Have you experienced any pain or soreness in the muscles of your face, head or neck? Y N

Do you get canker or "cold sores" in your mouth or on your lips? Y N

Do you smoke / chew tobacco? Y N How much? \_\_\_\_\_ Do you want to quit? Y N

Are you satisfied with your past dentistry? Y N

On a scale of 1 (highest) to 10 (lowest), how do you feel about the condition of your mouth? \_\_\_\_\_

On a scale of 1 (highest) to 10 (lowest), how would you like it to be? \_\_\_\_\_

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

How would you like your teeth to be 15 years from now? \_\_\_\_\_

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

On a scale of 1 (highest) to 10 (lowest), what is your interest in cosmetic dentistry? \_\_\_\_\_

Will insurance have a major role in achieving your objectives? Y N

Have you thought about a budget for your dental treatment? Y N