Dental History

How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
Previous Dentist_____ How long have you been a patient? _____Months/Years
Approximate date of most recent dental exam_____/____/____ Approximate date of most recent X-Rays _____/_____/_____
Approximate date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Did you ever have braces, orthodontic treatment or had your bite adjusted?	□ Yes □ No
Is there anything about the appearance of your teeth that you would like to change?	□ Yes □ No
Do you/would you have any problems chewing gum?	□ Yes □ No
Do you/would you have any problems chewing bagels or other hard foods?	□ Yes □ No
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	□ Yes □ No
Are your teeth crowding or developing spaces?	□ Yes □ No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	□ Yes □ No
Do you have any problems with sleep or wake up with an awareness of your teeth?	□ Yes □ No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	□ Yes □ No
Do you have tension headaches or sore teeth?	□ Yes □ No
Do you wear or have you ever worn a bite appliance?	□ Yes □ No
Have you ever had trouble getting numb or reactions to local anesthetic?	□ Yes □ No
Are you cavity prone?	□ Yes □ No

Please rate, in order of value, what is most important to you in your dental care:
(The most important will be #1.)
____ Preventive care
____ Only what is necessary at the time: Cost is important
____ Comprehensive, quality care
____ Other _____

Please rate, as above, what is most important to you in your relationship with a dentist:

____ Show me what he/she is doing or planning to do so I can clearly see what is happening.
____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.
____ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have regarding dental treatment.
(10 being the most fearful, 1 being the least amount of fear.)
1 2 3 4 5 6 7 8 9 10

Patient's signature_____ Date_____

Doctor's signature_____ Date_____