Smile Connections Family Dental, L.L.C.

DENTAL HISTORY

Name_____ Preferred Name _____D.O.B _____
Referred by_____ How would you rate the condition of your mouth? □Excellent □Good □Fair □Poor
Previous Dentist _____ How long have you been a patient? _____Months/Years_____
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than 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:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	□	□
2. Have you had an unfavorable dental experience? _____	□	□
3. Have you ever had complications from past dental treatment? _____	□	□
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	□	□
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	□	□
6. Have you had any teeth removed or missing teeth that never developed? _____	□	□
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	□	□
8. Have you ever whitened (bleached) your teeth? _____	□	□
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	□	□
10. Have you been disappointed with the appearance of previous dental work? _____	□	□
GUM AND BONE		
11. Do your gums bleed or are they painful when brushing or flossing? _____	□	□
12. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	□	□
13. Have you ever noticed an unpleasant taste or odor in your mouth? _____	□	□
14. Is there anyone with a history of periodontal disease in your family? _____	□	□
15. Do you have gum recession? _____	□	□
16. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?____	□	□
17. Have you experienced a burning or painful sensation, not related to your teeth, or sores or growths in your mouth?_____	□	□
TOOTH STRUCTURE		
18. Have you had any cavities within the past 3 years? _____	□	□
19. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	□	□
20. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	□	□
21. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	□	□
22. Do you have grooves or notches on your teeth near the gum line? _____	□	□
23. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	□	□
24. Do you frequently get food caught between any teeth? _____	□	□
25. Do you have a habit of chewing on one side of your mouth? _____	□	□
BITE AND JAW JOINT		
26. Do you have problems with your jaw joint around your ear or myofascial pain? (pain, sounds, limited opening, locking, popping)	□	□
27. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	□	□
28. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry food?_____	□	□
29. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	□	□
30. Are your teeth becoming more crooked, crowded, or overlapped? _____	□	□
31. Are your teeth developing spaces or becoming loose? _____	□	□
32. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	□	□
33. Do you place your tongue between your teeth or close your teeth against you tongue? _____	□	□
34. Do you chew ice, bite your nails, use your teeth to hold object, or have any other oral habits? _____	□	□
35. Do you clench or grind your teeth in the daytime or make them sore? _____	□	□
36. Do you have any problem with sleep (i.e. restlessness); wake up with a headache or an awareness of your teeth? _____	□	□
37. Do you wear or have you ever worn a bite appliance? _____	□	□

HABITS AND DIET

38. Do you mouth breath? □ YES □ NO
39. Have you ever had a habit of: □ smokeless tobacco_____ □ thumb sucking_____
□ toothpick/gum stimulator_____□ gum chewing_____ □ candy_____ □ soda_____

Other habits: _____
How often do you brush? _____ How often do you floss? _____
Toothpaste _____ Mouthwash _____

Patient Signature _____ Date _____
Doctor Signature _____ Date _____