DENTAL HISTORY

ELEVATE FAMILY DENTISTRY

PATIENT NAME: DATE OF BIRTH: TODAY'S DATE:

NAME OF PREVIOUS DENTIST: DATE OF LAST DENTAL EXAM:

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH: □ EXCELLENT □ GOOD □ FAIR □ POOR

I ROUTINELY SEE MY DENTIST EVERY: □ 3 MOS □ 4 MOS □ 6 MOS □ 12 MOS □ NOT ROUTINELY

WHAT IS YOUR IMMEDIATE CONCERN?

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE? (COLOR, SHAPE, POSITION…):

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful from a scale of 1 (least) to 10 (most) _____	□	□
Would you be interested in nitrous oxcide?	□	□
1. Have you ever had an unfavorable dental experience?	□	□
2. Have you ever had complications with past dental treatment?	□	□
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?	□	□
4. Have you ever had braces, other orthodontic treatment or had your bite adjusted? If yes, what age? _____	□	□
5. Have you ever had teeth removed , missing teeth that never developed or lost teeth due to trauma/injury?	□	□
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	□	□
8. Have you ever been treated for gum disease or been told you have bone loss around your teeth?	□	□
9. Have you ever noticed an unpleasant taste or odor in your mouth?	□	□
10. Is there anyone in your family with a history of periodontal (gum) disease?	□	□
11. Have you ever experienced gum recession?	□	□
12. Have you ever had any teeth become loose on their own (without injury)?	□	□
13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth?	□	□
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	□	□
15. Does the saliva in your mouth seem too little or do you have difficulty swallowing any food?	□	□
16. Do you notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	□	□
17. Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth (circle all that apply)	□	□
18. Do you have grooves or notches on your teeth near the gumline?	□	□
19. Have you ever had broken or chipped teeth?	□	□
20. Have you ever had a toothache or cracked filling?	□	□

FOR FRONT OFFICE USE ONLY: DATE SCANNED _____

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BITE AND JAW JOINT	YES	NO
22. Do you have problems with your jaw joints (pain, clicking, popping, limited opening)?	☐	☐
23. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your Bite changed?	☐	☐
24. Have your teeth become more crooked, crowded or overlapped?	☐	☐
25. Are your teeth developing spaces or becoming more loose?	☐	☐
26. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
27. Do you chew on ice, bite your nails, use your teeth to hold objects or any other similar habits?	☐	☐
28. Do you clench or grind your teeth during the day or make them sore?	☐	☐
29. Do you or have you ever worn a night guard?	☐	☐
SMILE CHARACTERISTICS		
30. Have you ever whitened your teeth?	☐	☐
31. Are you uncomfortable or self conscious about the appearance of your teeth?	☐	☐
34. Have you ever been disappointed with the appearance of previous dental work?	☐	☐
IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?	☐	☐

_____

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

FOR FRONT OFFICE USE ONLY: DATE SCANNED _____