DENTAL HEALTH HISTORY

H. Dental Visits

1. Name of your Former Dentist: _____ How long since you were last seen? _____

2. What is the reason for your visit today? ☐Broken tooth ☐Check-up ☐Cosmetic ☐Dentures ☐Tooth Pain ☐Other: _____

3. Is keeping your teeth important to you? [Y] [N] If yes, why? _____

4. On a scale of 1-10, 10 being the best, where would you rate your smile?

5. On a scale of 1-10, 10 being the best, where would you rate your oral health?

6. Have you experienced any of the following problems:

Dry Mouth [Y] [N]
Bleeding gums [Y] [N]
Bad Breath or sour taste in mouth [Y] [N]
Burning sensations in mouth [Y] [N]
Soreness in jaw [Y] [N]
Is it hard for you to open wide [Y] [N]
Clicking or popping in jaw [Y] [N]
Have you or your parents suffer(ed) from Gum Disease [Y] [N]
Did you ever wear braces [Y] [N]
Oral Surgery of any kind [Y] [N]

Sensitivity to Hot & Cold [Y] [N]
Snoring [Y] [N]
Food catching between teeth [Y] [N]
Clenching or grinding of teeth [Y] [N]
Mouth Ulcers [Y] [N]
Frequent headaches? [Y] [N]
Pain/soreness around ears, eyes, face [Y] [N]
Stiff Neck Muscles [Y] [N]
Ever been injured in your mouth or head [Y] [N]
Do you or your parents wear dentures/partials [Y] [N]
Do you smoke or chew tobacco [Y] [N]

7. Have you ever had novocaine or other local anesthetic? [Y] [N]
8. Have you ever been treated for periodontal (gum) disease? [Y] [N]

9. Does dental treatment make you afraid or nervous? [Y] [N] What specific things bother you? _____

10. Is the brightness of your teeth important to you? [Y] [N]

11. If you could change anything about your smile which of the following would you want?

Whiter [Y] [N]
Replace missing teeth [Y] [N]
Remove Stains/Spots on teeth [Y] [N]
Straighter [Y] [N]

Close space or spaces [Y] [N]
Replace old crowns [Y] [N]
Excess showing of Teeth [Y] [N]
Less Gum showing [Y] [N]
Show more teeth [Y] [N]

Repair or replace chipped teeth [Y] [N]
Remove mercury silver fillings [Y] [N]
Replace old colored filling(s) [Y] [N]
Reshape/resize my teeth [Y] [N]

12. Fill in this question for us please: Together, what goals would you like for your oral health lifetime care?

13. **Please indicate which of the following are important to you when making your dental health decision.**

☐ Convenience
☐ Finances
☐ What insurance covers
☐ Fear or Anxiety
☐ Appearance
☐ Time
☐ Health
☐ Comfort
☐ Relationship with Dental Team
☐ Quality of care
☐ Detailed treatment explanations
☐ Technology

Patient Signature: _____ **Date:** _____