New Baltimore Family Dentistry

Dental History

PATIENT INFORMATION

First Name		Middle Initial		Last Name	
Preferred Name				Date of Birth	

DENTAL HISTORY

Referred by				
How would you rate the condition of your mouth?	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Previous Dentist		How long were you a patient?	Months/Years	
Date of most recent dental exam		Date of most recent x-rays		
Date of most recent treatment (other than a cleaning)?				
I routinely see my dentist every:	❑ 3 months	❑ 4 months	❑ 6 months	❑ 12 months ❑ Not routinely
What is your immediate concern?				

Please answer YES or NO to the following:

PERSONAL HISTORY

1. Are you fearful of dental treatment?	❑ Yes ❑ No	How fearful, on a scale of 1 (least) to 10 (most)?		
2. Have you had an unfavorable dental experience?			❑ Yes	❑ No
3. Have you ever had complications from past dental treatment?			❑ Yes	❑ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?			❑ Yes	❑ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?			❑ Yes	❑ No
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?			❑ Yes	❑ No

GUM AND BONE

7. Do your gums bleed sometimes or are they painful when brushing or flossing?	❑ Yes	❑ No
8. Have you ever been treated for gum disease, had scaling or root planning, or been told you have lost bone around your teeth?	❑ Yes	❑ No
9. Have you ever noticed an unpleasant taste or odor in your mouth?	❑ Yes	❑ No
10. Is there anyone with a history of periodontal disease in your family?	❑ Yes	❑ No
11. Do you have gum recession or can you see more of the roots of your teeth?	❑ Yes	❑ No
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	❑ Yes	❑ No
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	❑ Yes	❑ No

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?	❑ Yes	❑ No
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	❑ Yes	❑ No
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	❑ Yes	❑ No
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	❑ Yes	❑ No
18. Do you have grooves or notches on your teeth near the gum line?	❑ Yes	❑ No
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	❑ Yes	❑ No
20. Do you frequently get food caught between any teeth?	❑ Yes	❑ No

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping)	❑ Yes	❑ No
22. Do you feel like your lower jaw is being pushed back when you try to bite your teeth together?	❑ Yes	❑ No
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	❑ Yes	❑ No

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24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	❑ Yes ❑ No
25.	Are your teeth becoming more crooked, crowded, or overlapped?	❑ Yes ❑ No
26.	Are your teeth developing spaces or becoming more loose?	❑ Yes ❑ No
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together or shift your jaw to make your teeth fit together?	❑ Yes ❑ No
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	❑ Yes ❑ No
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	❑ Yes ❑ No
30.	Do you clench or grind your teeth in the daytime or make them sore?	❑ Yes ❑ No
31.	Do you have any problems with sleep (restlessness or teeth grinding) or wake up with a headache or an awareness of your teeth?	❑ Yes ❑ No
32.	Do you wear or have you ever worn a bite appliance?	❑ Yes ❑ No

SMILE CHARACTERISTICS

33.	Is there anything about your mouth's appearance (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	❑ Yes ❑ No
34.	Have you ever whitened (bleached) your teeth?	❑ Yes ❑ No
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	❑ Yes ❑ No
36.	Have you been disappointed with the appearance of previous dental work?	❑ Yes ❑ No

FORM COMPLETION

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member or his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian		**Date**	
If Patient is a Minor			
Form signed by		**Relationship to Patient**	