

Patient Name: _____

Date: _____

Dental History

Thank you for considering our practice! Please describe any dental problems or concerns you are having at this time: _____

Do you have any pain when you chew or bite? _____ If yes, where? When? _____

Do you have any teeth that are sensitive to hot, cold, or sweets? _____ If yes, when? _____

How often do you have your teeth examined and cleaned? _____
When was the last time you had a complete set of dental x-rays? _____

Have you needed much dental work in the past? _____ If yes, please briefly describe what has been done: _____

How do you feel about the *quality* of dental care you have received up to this point?

Are you missing any teeth? _____ If yes, do you regret losing any of them? _____

Have you ever worn braces? _____ If yes, when? _____ For how long? _____

Does your bite feel comfortable? _____
Can you chew as well as you would like to? _____

Are you satisfied with the appearance of your teeth? _____ If no, what is it that you do not like about your teeth / smile? _____

What is your typical daily oral hygiene routine? _____

Do your gums bleed when you brush your teeth? _____

Have you ever been *told* that you have gum disease? _____

Have you ever been *treated* for gum disease? _____

Did / do your parents have gum disease? _____

Did / do your parents wear dentures? _____

How often do you suffer from bad breath? _____ Never _____ Seldom _____ Often

Do you use gum, breath mints, or cough drops? _____ Never _____ Seldom _____ Often

How often do you snack between meals? _____ Never _____ Seldom _____ Often

Do your jaw joints ever click, pop, hurt or lock-up? _____

(continued to back)

Have you ever been treated for "TMJ"? _____

Would you consider your daily diet to be: _____ Healthy _____ Good _____ Poor

Do you exercise regularly? _____ No _____ Yes If yes, what do you typically do? _____

Do you sleep well at night? _____ No _____ Yes Do you awaken well rested? _____ No _____ Yes

Do you use or have recently used tobacco products? _____ No _____ Yes

How much of a priority is it for you to keep your natural teeth over your lifetime?

(Circle) **Very high priority** **somewhat high** **not sure yet** **low priority**

How would you rate your *current* dental health?

Perfect **Good** **Fair** **Poor** **Hopeless**
(Circle) 10 9 8 7 6 5 4 3 2 1

How do you feel about visiting our office today?

(Circle) **Excited** **Hopeful** **Concerned** **Afraid** **Other:** _____

What concerns you *most* about visiting the dentist? _____

What elements of dental care are your top priorities at this time?

Please Check

- _____ **Clean your teeth**
- _____ **Identify and address *current* problems**
- _____ **Work with you to *create long-range strategies* which can create and maintain the health of your teeth and smile over your lifetime.**
- _____ **Work with you to identify ways to *improve the appearance of your teeth/smile.***

Optional

We know that excessive stress can negatively influence all aspects of our health. What do you feel are the biggest sources of stress you are facing these days? _____

Is there anything else that you would like us to know or focus on at this first visit? _____

Patient Signature

Date