Nathan Bird, DMD, PLLC
Family Dentistry

# DENTAL HISTORY

Patient Name ________________________________________________ Nickname ______________________ Age ___________

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 examination _______/_______/_______ Date of most recent x-rays _______/_______/_______

Date of most recent treatment (other than a cleaning) _______/_______/_______

I routinely see my dentist every ____ 3 mo. ____ 4 mo. ____ 6 mo. ____ 12 mo. ____ Not Routinely

What is your immediate concern? ______________________________________________________________________________

| | Yes | No |
|---|---|---|
| **PERSONAL HISTORY** | | |
| 1. Are your 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? | ____ | ____ |
| **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 lost bone around your teeth? | ____ | ____ |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? | ____ | ____ |
| 10. Is there anyone with a history of periodontal disease in your family? | ____ | ____ |
| 11. Have you ever experienced gum recessions? | ____ | ____ |
| 12. Have you ever had any teeth become loose on their own (without injury) or do you have difficulty eating an apple? | ____ | ____ |
| 13. Have you 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 amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | ____ | ____ |
| 16. Do you feel or notice any holes (pitting, craters) on the biting surface of your teeth? | ____ | ____ |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? | ____ | ____ |
| 18. Do you have grooves or notches on your teeth near the gum line? | ____ | ____ |
| 19. Have you ever broken teeth, or had a toothache or cracked filling? | ____ | ____ |
| 20. Do you frequently get food caught between any teeth? | ____ | ____ |
| **BITE AND JAW JOINT** | | |
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening locking, popping) | | |
| 22. Do you feel like your lower jaw is being pushed back when you bite you bite your teeth together? | ____ | ____ |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, other hard dry foods? | ____ | ____ |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | ____ | ____ |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? | ____ | ____ |
| 26. Are your teeth developing spaces or becoming more loose? | ____ | ____ |
| 27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? | ____ | ____ |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | ____ | ____ |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | ____ | ____ |
| 30. Do you clench your teeth in the daytime or make them sore? | ____ | ____ |
| 31. Do you have any problems with sleep (restlessness), wake up with a headache or an awareness of your teeth? | ____ | ____ |
| 32. Do you wear or have you ever worn a bite appliance? | ____ | ____ |
| **SMILE CHARACTERISTICS** | | |
| 33. Is there anything about the appearance of your teeth that you would like to change? | ____ | ____ |
| 34. Have you ever whitened (bleached) your teeth? | ____ | ____ |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? | ____ | ____ |
| 36. Have you been disappointed with the appearance of previous dental work? | ____ | ____ |

Patient's Signature ____________________________________________ Date ___________________________________

Doctor's Signature ____________________________________________ Date ___________________________________