



Family & Cosmetic Dentistry

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Patient Personal Information:

Name: _____ Age: _____ DOB: _____

DENTAL HISTORY

Previous Dentist: _____ Address: _____

Date of most recent dental exam: ____/____/____ Date of most recent x-rays: ____/____/____

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

WHAT IS YOUR REASON FOR COMING TO THE DENTIST TODAY? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very): _____ YES NO
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 reactions to local anesthetic? _____ YES NO
5. Do you currently have any dental implants, dentures or partials? _____ YES NO
6. Do you premedicate for your dental appointment? _____ YES NO

SMILE CHARACTERISTICS

7. Are you self conscious about your teeth? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO

BITE AND JAW JOINT

10. Do you grind or clench your teeth? _____ YES NO
11. Do you have problems with your jaw joint or facial muscles? (pain, sounds, limited opening, locking, popping) _____ YES NO
12. Do you have tension headaches or sore teeth? _____ YES NO
13. Do you wear or have you ever worn a bite appliance? _____ YES NO
14. Do you play any sports? _____ YES NO
15. If so do you wear an athletic mouth guard? _____ YES NO

TOOTH STRUCTURE

16. Do you have a dry mouth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting or sweets? _____ YES NO
18. Are any of your teeth causing you pain? _____ YES NO

GUM AND BONE

19. Have you ever been diagnosed or treated for periodontal disease? _____ YES NO
20. Do your gums bleed when brushing, flossing or eating? _____ YES NO
21. Do you experience bad breath? _____ YES NO
22. Do you suffer from mouth ulcers or sores? _____ YES NO
23. Do you snore or have been diagnosed with sleep apnea? _____ YES NO

Patient Signature: _____ Date: _____

Parent, Guardian, Legal Representative Signature: _____

Doctor's Signature: _____ Date: _____