GREAT SMILE DENTAL

DENTAL HISTORY

Name: _____ DOB: _____

Please rate the following, with 1 being very poor and 5 being excellent.

1. How do you feel your overall dental health is? 1 2 3 4 5
2. Are you currently in dental pain? Yes No
3. What is your level of sensitivity to dental procedures (5= severe, 1=none)? 1 2 3 4 5
4. How long ago was your last dental visit? _____
5. Do you require antibiotics before dental treatment? Yes No

   If yes, why? _____
6. Previous dentist's name and office location: _____
7. May we request x-rays and records from your previous dentist? Yes No
8. Do you have any dental concerns at the moment? Yes No

   If yes, please explain:

   _____
   _____
   _____
9. Do you have any concerns about previous dental care? Yes No

   If yes, please explain:

   _____
   _____
   _____
10. Do you have dental anxiety? Yes No
11. Do your gums bleed when brushing or flossing? Yes No
12. Are any of your teeth loose? Yes No
13. Are your teeth sensitive to any of the following (circle all that apply)? Sweets Cold Heat Pressure

14. Do you get mouth sores? Yes No

If yes, please explain: _____

15. Do you have a dry mouth? Yes No

16. Have you ever been told that you have bad breath? Yes No

17. Do you or have you ever been told you grind or clench your teeth? Yes No

a. Do you wear a night guard? Yes No

18. Have you ever had any pain or clicking or popping in your jaw joints? Yes No

19. Have ever been treated for TMJ problems? Yes No

20. Have you ever been treated for oral cancer? Yes No

21. Do you have recurring or frequent headaches, migraines? Yes No

22. Do you have frequent earaches or neck pains? Yes No

23. Have you ever had any of the following dental procedures/treatment?

a. "Deep" dental cleaning or root planning/curettage? Yes No

b. Gum Surgery (periodontal surgery)? Yes No

c. Have you had any teeth extracted? Yes No

i. If yes, why? _____

d. Do you have tooth colored (composites) or silver fillings (amalgam)? Yes No

e. Crowns or bridges? Yes No

f. Orthodontia (braces)? Yes No

g. Root canal? Yes No

h. Dental implant? Yes No

i. Do you consider yourself to be susceptible to dental decay (cavities)? Yes No

j. Do you have a removable dental appliance? Yes No

k. Teeth whitened? Yes No

24. Have any of your family members had gum disease? Yes No

25. Do you smoke and/or use smokeless tobacco? Yes No

a. If yes, how interested are you in stopping (1: Not at all, 5: Incredibly)? 1 2 3 4 5

b. Are you a former tobacco user? Yes No

c. If you have stopped using tobacco, how long ago did you stop? _____

d. Do you smoke/ingest marijuana? Yes No

26. Do you drink alcoholic beverages? Yes No

If yes, how often? _____

27. Questions regarding your daily oral hygiene habits:

a. Do you BRUSH daily? Yes No

b. Do you clean between your teeth daily? Yes No

If yes, what device do you use and how often?

i. Dental floss? Yes No How often: _____

ii. Tooth picks? Yes No How often: _____

iii. Oral Irrigator? Yes No How often: _____

c. Do you use mouthwash? Yes No

d. Do you clean your tongue? Yes No

Are you happy with your smile? Yes No

If no, what would you like to change?

_____

_____

What would you change about the present condition of your mouth, if anything?

_____

_____

What do you hope for or expect from your dental team?

_____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers provided here are accurate.

Patient signature: _____ Date _____