DENTAL HISTORY

Patient Name: ___________________________________ DOB: _______________ Today's Date: _______________

Previous Dentist: _____________________________________ Date of most recent dental exam: ________________

Date of most recent x-rays: ____________ Date of most recent dental treatment (other than a cleaning): _____________

How would you rate the condition of your mouth?: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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: **Yes No**

PERSONAL HISTORY

1. Are you fearful of dental treatment? What is your level of dental anxiety? _______ (1-least, 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. Have you ever had braces, orthodontic treatment or had your bite adjusted, and at what age?......................... ☐ ☐
6. Have you had any teeth removed, missing teeth or lost teeth due to injury or facial trauma?............................ ☐ ☐
7. Do you use an electric toothbrush?... ☐ ☐
8. Do you floss daily?... ☐ ☐
9. Do you currently use prescription fluoride toothpaste (e.g. Clinpro 5000, Prevident 5000)? …………………….. ☐ ☐
10. Which of these factors matter most to your dental health? Can be multiple answers.
    - ☐ Appearance of your smile
    - ☐ Long lasting dentistry
    - ☐ Your comfort (you're free from cavities, gum disease and infection)
    - ☐ Functionality of your teeth
11. When considering treatment options for your care, which of these are concerns for you? Can be multiple answers.
    - ☐ Fear of dental work
    - ☐ Lack of trust with dentists
    - ☐ Treatment not important right now
    - ☐ Not the right time for me to have treatment done
    - ☐ Cost of dental care
12. When it comes to explaining your dental treatment, which is best for you? Can be multiple answers.
    - ☐ I'm a visual person so I want to see photos, x-rays, drawings, etc.
    - ☐ I want to know why and I want everything explained with every little detail
    - ☐ Just give me enough detail so I understand my treatment
    - ☐ Just tell me what I need to do, spare all the details
    - ☐ I like multiple options that I can pick and choose (e.g. dentures, implants, bridges)
    - ☐ I want what Dr. Wonder thinks is best for my teeth/mouth

GUM AND BONE

13. Do your gums bleed or are they painful when brushing or flossing?... ☐ ☐
14. Have you ever been treated for gum disease or been told you have lost bone around your teeth?.................... ☐ ☐
15. Have you ever noticed an unpleasant taste or odor in your mouth?.. ☐ ☐
16. Is there anyone in your family with a history of periodontal (gum) disease?.. ☐ ☐

17. Have you ever experienced a gum recession?.. ☐ ☐
18. Have you ever had any teeth become loose on their own (without an injury)?.. ☐ ☐
19. Have you experienced a burning or painful sensation in your mouth not related to your teeth?........................... ☐ ☐

TOOTH STRUCTURE

20. Have you ever had any cavities within the past 3 years?... ☐ ☐
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?............ ☐ ☐
22. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?................................... ☐ ☐
23. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?............... ☐ ☐
24. Do you have or feel grooves or notches on your teeth near the gum line?... ☐ ☐
25. Have you ever broken teeth, chipped/cracked teeth or had a toothache or cracked fillings?.............................. ☐ ☐
26. Do you frequently get food caught between any teeth?.. ☐ ☐

BITE AND JAW JOINT

27. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)............................. ☐ ☐
28. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?................. ☐ ☐
29. Do you avoid or have difficulty chewing gum, carrots, nuts, baguettes, or other hard dry foods?........................ ☐ ☐
30. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?...... ☐ ☐
31. Are your teeth becoming more crooked, crowded, or overlapped?... ☐ ☐
32. Are your teeth developing spaces or becoming more loose?.. ☐ ☐
33. Do you have trouble finding your bite or shift your jaw to make your teeth fit together?..................................... ☐ ☐
34. Do you place your tongue between your teeth or close your teeth against your tongue?.................................... ☐ ☐
35. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ………………… ☐ ☐
36. Do you clench or grind your teeth together in the daytime or make them sore?……………………………………. ☐ ☐
37. Do you have any problems with sleep (i.e. restless or teeth grinding), or wake up with a headache?................. ☐ ☐
38. Do you wear or have you ever worn a bite appliance (i.e. TMJ appliance or a night guard)................................ ☐ ☐
39. If needed, would you like to discuss orthodontic treatment (braces) with Dr. Wonder?....................................... ☐ ☐

SMILE CHARACTERISTICS

40. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?.......... ☐ ☐
41. Have you ever whitened (bleached) your teeth?.. ☐ ☐
42. Do you feel uncomfortable or self-conscious about the appearance of your teeth or when you smile?................ ☐ ☐
43. Have you been disappointed with the appearance of previous dental work?... ☐ ☐

44. Would you like to discuss the whitening procedure with Dr. Wonder?... ⬜ ⬜

SLEEP & BREATHING

45. Do you have trouble breathing through your nose?.. ⬜ ⬜
46. If Dr. Wonder sees oral/dental signs of sleep related breathing disorders, would you like to take a complimentary Home Sleep Test?.. ⬜ ⬜

Patient/Parent/Guardian Signature: ____ **Date:** ___________________