Total Care Dental

Dental History

Name__________________________ Date ________

Please answer yes or no to the following Yes No

Personal Dental History

1. Are you fearful of dental treatment? Scale of 1 to 10_______________________________ ☐ ☐
2. Have you ever had an unfavorable dental experience?______________________________ ☐ ☐
3. Have you ever had complications from past dental treatment?_____________________ ☐ ☐
4. Have you ever had trouble getting numb or reactions to the anesthetic?_____________ ☐ ☐
5. Did you ever have braces or have your bite adjusted?______________________________ ☐ ☐
6. Have you had any teeth removed?____ ☐ ☐

Smile Information

7. Is there anything about the appearance of your teeth that you would like to change?_ ☐ ☐
8. Have you ever whitened (bleached) your teeth?___________________________________ ☐ ☐
9. Have you ever been disappointed with the appearance of previous dental work?____ ☐ ☐

Bite and Jaw Joint Information

10. Do you/ would you have problems chewing gum?_______________________________ ☐ ☐
11. Do you/ would you have any problems chewing bagels or other hard foods?________ ☐ ☐
12. Have your teeth changed in the last 5 years, become shorter, thinner or worn?______ ☐ ☐
13. Are your teeth crowding or developing spaces?__________________________________ ☐ ☐
14. Do you have more than one bite , or do you squeeze to make your teeth fit together?_ ☐ ☐
15. Do you have any problems with sleep or wake up with an awareness of your teeth?__ ☐ ☐
16. Do you have problems with your jaw joint?(Pain, sounds, locking, popping)___________ ☐ ☐
17. Do you have tension headaches or sore teeth?___________________________________ ☐ ☐
18. Do you wear or have you ever worn a bite appliance?_____________________________ ☐ ☐

Tooth Information

19. Have you had any cavities within the past three years?____________________________ ☐ ☐
20. Do you feel like you have too little saliva or have trouble swallowing food?__________ ☐ ☐
21. Are any teeth sensitive to hot, cold, biting, sweets or toothbrushing?________________ ☐ ☐
22. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?____ ☐ ☐
23. Do you frequently get food caught between teeth?_______________________________ ☐ ☐
24. Do you feel any holes or grooves in your teeth (chewing surface or gumline)?_______ ☐ ☐

Gum and Bone Information

25. Have you ever been diagnosed or treated for periodontal (gum) disease?___________ ☐ ☐
26. Have you ever experienced gum recession? _____________________________________ ☐ ☐
27. Is there anyone with a history of periodontal disease in your family?_______________ ☐ ☐
28. Do your gums bleed or are they painful when flossing , brushing or eating?__________ ☐ ☐
29. Are your teeth becoming loose or do you have trouble eating an apple?_____________ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?_________________ ☐ ☐
31. Have you ever experienced a burning sensation in your mouth? ___________________ ☐ ☐

Patient Signature____________________________________ Dr. Signature__________________________