BEACH CITIES DENTAL GROUP

DENTAL HISTORY

NAME:_____ DATE:____/____/_____

PLEASE ANSWER **YES** OR **NO** TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience or have dental work you don't like?	☐	☐
3. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
4. Do you snore and/or have trouble sleeping	☐	☐
5. Do you suffer from frequent headaches or migraines?	☐	☐
SMILE CHARACTERISTICS		
1. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
2. Are your teeth as straight as you would like them to be?	☐	☐
3. Do you have any discolorations, stains or spots on your teeth?	☐	☐
4. Would you like whiter teeth?	☐	☐
5. Do you have silver fillings or old crowns you would like changed?	☐	☐
6. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
BITE AND JAW JOINT		
1. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
2. Do you have any problems chewing gum, nuts, or any other hard foods?	☐	☐
3. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
4. Are your teeth crowding or developing spaces?	☐	☐
5. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
6. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
7. Do you clench your teeth in the daytime or nighttime?	☐	☐
8. Do you wear or have you ever worn a nightguard?	☐	☐
TOOTH STRUCTURE		
1. Have you had any cavities within the past 3 years?	☐	☐
2. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
5. Do you have grooves or notches on your teeth near the gum line?	☐	☐
6. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
7. Do you get food caught between any teeth?	☐	☐
GUM AND BONE		
1. Do your gums bleed when brushing or flossing?	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
3. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
4. Have your gums receded in any area of your mouth?	☐	☐
5. Have you ever had any teeth become loose on their own without injury, or do you have difficulty eating an apple?	☐	☐

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

OFFICE PERSONNEL NOTES