Dental History Form (14+ years old)

Patient Name: _____ Today's Date: _____

Please answer the following questions with a **Y**, **N**, **DK**, or **N/A**:

Are your currently experiencing dental pain or discomfort? _____ If yes, where? _____

Do your gums bleed? _____

Are your teeth sensitive to:
Hot? _____ Cold? _____ Sweets? _____ Pressure? _____

Is your mouth dry? _____

Have you ever had a periodontal treatment (aka deep cleaning, scaling & root planing)? _____

Have you ever had orthodontic treatment? _____
Do your wear retainers? _____

Do you wear a nightguard? _____

Do you have: Earaches? _____ Neck pain? _____ Headaches? _____

Do you have: Jaw clicking/popping? _____ Jaw/facial discomfort? _____

Do you:
Grind/clench your teeth? _____
Snore? _____
Have Sleep Apnea? _____
Use a CPAP? _____
Have trouble breathing through your nose? _____

Do you wear dentures? _____ Partials? _____

Do you participate in recreational activities (basketball, soccer, tennis, golf, etc)? _____
Do you wear a sports mouthguard? _____

Have you had a serious injury to your head or mouth? _____

We make every effort to be extremely gentle, caring and patient to put you at ease and address your apprehensions. If you have concerns about dental fears and anxieties, feel free to speak with Dr. Jones personally so that we can work through it together.

My dental anxiety/fear level is: __1_____5_____10__
LOW MODERATE HIGH

Please tell us more, if you wish?

SMILE SURVEY

- Are you happy with the appearance of your teeth, gums, and smile? **YES NO**
    - Now that you mention it…can we talk about _____?
- Would you like to discuss if you are a good candidate for teeth whitening? **YES NO**