DOWNTOWN DT DENTAL - DENTAL INFORMATION

How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
What is your primary dental concern?_____
Who was your Previous Dentist? _____
Approximate Date of Most Recent Dental Appointment?_____
How often to you see the Dentist? □ 3 mo □ 6 mo □ 12 mo □ not regularly

Personal History	**Yes**	**No**
Are you fearful of dental treatment?	□	□
Have you had an unfavourable dental experience?	□	□
Have you ever had complications from past dental treatment?	□	□
Have you ever had trouble getting numb or had any reactions to local aesthetic?	□	□
Did you ever have braces, orthodontic treatment, or had your bite adjusted?	□	□
Have you had any teeth removed?	□	□
Gum & Bone		
Do your gums bleed, or are they painful when brushing or flossing?	□	□
Have you ever been told you have gum disease?	□	□
Have you ever noticed an unpleasant taste or odour in your mouth?	□	□
Is there anyone with a history of periodontal disease in your family?	□	□
Have you ever experienced gum recession?	□	□
Have you ever had any teeth become loose on their own?	□	□
Have you experienced a burning sensation in your mouth?	□	□
Tooth Structure		
Have you had any cavities within the past 3 years?	□	□
Do you have a dry mouth or do you have difficulty swallowing?	□	□
Do you feel or notice any holes on the biting surface of your teeth?	□	□
Are you teeth sensitive to hot, cold, biting. sweets or brushing?	□	□
Do you have grooves or notches in your teeth near the gum line?	□	□
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	□	□
Do you frequently get food caught between any teeth?	□	□
Bite & Jaw Joint		
Do you have problems with your jaw joint (pain, sounds, limited opening, locking)?	□	□
Do you feel like your lower jaw is being pushed back when you bite together?	□	□
Do you have difficulty chewing gum, carrots, nuts, bagels, or protein bars?	□	□
Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	□	□
Are your teeth crowding or developing spaces?	□	□
Do you have more than one bite and squeeze to make your teeth fit together?	□	□
Do you chew ice, bite your nails, use your teeth to hold items, or have any oral habits?	□	□
Do you clench your teeth in the daytime or make them sore?	□	□
Do you have problems with sleep or wake up with an awareness of your teeth?	□	□
Do you wear or have you ever worn a bite appliance?	□	□
Smile Characteristics		
Is there anything about the appearance of your teeth that you would like to change?	□	□
Have you ever whitened (bleached) your teeth?	□	□
Have you felt uncomfortable or self conscious with the appearance of your teeth?	□	□
Have you been disappointed with the appearance of previous dental work?	□	□

Patient Name:_____

Patient Signature:_____Date:_____