Dicus Family Dentistry

Name: _____ Age: _____

Dental History:

How would you rate the condition of your mouth? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Previous Dentist:_____ How long have you been a patient?____ Months/Years
Date of most recent cleaning? ____/____/____ Date of most recent treatment____/____/____
I routinely see my dentist every: [ ] 3 mos. [ ] 4 mos. [ ] 6 mos. [ ] 12 mos. [ ] not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment? Scale of 1 to 10 (10 = highest) _____	[ ]	[ ]
Have you had an unfavorable dental experience? _____	[ ]	[ ]
Have you ever had complications from past dental treatment? _____	[ ]	[ ]
Have you ever had trouble getting numb or reactions to local anesthetic? _____	[ ]	[ ]
Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	[ ]	[ ]
Have you had any teeth removed? _____	[ ]	[ ]

BITE AND JAW JOINT		
Do you/would you have any problems chewing gum? _____	[ ]	[ ]
Do you/would you have any problems chewing bagels or other hard foods? _____	[ ]	[ ]
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 or do you clench (squeeze to make your teeth fit together?)____	[ ]	[ ]
Do you have any problems with sleep or wake up with an awareness of your teeth? _____	[ ]	[ ]
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ___	[ ]	[ ]
Do you have tension headaches or sore teeth? _____	[ ]	[ ]
Do you wear or have you ever worn a bite appliance? _____	[ ]	[ ]

TOOTH STRUCTURE		
Have you had any cavities within the past 3 years? _____	[ ]	[ ]
Do you have a dry mouth? _____	[ ]	[ ]
Are any teeth sensitive to hot, cold, biting or sweets? _____	[ ]	[ ]
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	[ ]	[ ]
Do you avoid brushing any part of your mouth? _____	[ ]	[ ]
Do you feel or notice any holes (i.e. pitting) in your teeth? _____	[ ]	[ ]

GUM AND BONE		
Have you ever been diagnosed or treated for periodontal (gum) disease? _____	[ ]	[ ]
Have you ever experienced gum recession? _____	[ ]	[ ]
Is there anyone with a history or periodontal disease in your family? _____	[ ]	[ ]
Do your gums bleed when brushing, flossing or eating? _____	[ ]	[ ]
Are your teeth becoming loose? _____	[ ]	[ ]
Have you ever noticed an unpleasant taste, odor or burning sensation in your mouth? _____	[ ]	[ ]

Patient's Signature: _____ Date:_____