Masterpiece Family & Cosmetic Dentistry

Dental History

Patient Name:_____ Date:_____

1. What prompted you to seek dental care at this time?_____
2. At what age did you first visit a dentist?_____
3. When was your last dental visit?_____
4. What was done at that appointment?_____
5. How often did you visit a dentist before then?_____
6. Are you happy the way your present dental work looks? No Yes
7. Do you have pain while chewing or biting? No Yes
8. Do you feel pain when your teeth contact heat, cold or sweets? No Yes
9. Do any of your teeth get sore? No Yes
10. Are you able to chew on your back teeth effortlessly and comfortably? No Yes
11. Are you aware of any broken teeth or fillings? No Yes
12. Do your gums feel tender or swollen? Where?_____ No Yes
13. Does food wedge between your teeth? Where?_____ No Yes
14. Do you clinch or grind your teeth at night or during the day? No Yes
15. Are your front upper or lower teeth worn? No Yes
16. Do you hear popping or clicking when you open or close your mouth? No Yes
17. Do you have frequent headaches? How often?_____ No Yes
18. Are you in the habit of biting your finger nails or any other hard objects? No Yes
19. Do you ever wake up with at tired or aching feeling in your jaw, jaw muscles, jaw joints, or around your ear? No Yes
20. Do you at times have difficulty in chewing? No Yes
21. Do both sides of your mouth touch evenly? No Yes
22. Do you chew on one side more than the other? Which side?_____ No Yes
23. Have you ever had your teeth straightened? When?_____ No Yes
24. Excluding braces, have any of your teeth loosened, tipped, or shifted in the past five years? No Yes
25. Do you understand the meaning of the words “traumatic occlusion”? No Yes
26. Have there been any injuries to the face, mouth or teeth? When?_____ No Yes
27. What tooth paste do you most frequently use? _____ Mouthwash?_____
28. Were you raised on or now have well water? No Yes
29. Do you drink bottle or flavored water? How often? _____ No Yes
30. Do you avoid any part of your mouth while brushing? Where?_____ No Yes
31. Do you use dental floss? How often?_____ No Yes
32. Do your gums bleed while flossing? Never Sometimes Always No Yes

Masterpiece Family & Cosmetic Dentistry

Dental History

Patient Name:_____ Date:_____

33. Do you use any other type of cleaning device for oral hygiene? What?_____ No Yes
34. Did you know that when gums bleed, periodontal disease is already present? No Yes
35. Did you know extensive destruction can take place under the gum line without you even knowing it? No Yes
36. Do you feel that you have bad breath at times? When?_____ No Yes
37. Do you ever have an unpleasant taste in your mouth? When?_____ No Yes
38. Have you ever had periodontal treatment? When?_____ No Yes
39. Have you ever had teeth removed? Why?_____ No Yes
40. How often do you brush your teeth?_____
41. What is the texture of the toothbrush you are currently using? Hard Medium Soft
42. Do you brush your teeth…….. Lightly Vigorously
43. How often do you have your teeth professionally cleaned?_____
44. Do you feel that you now clean your mouth properly? No Yes
45. Do you think your dental disease is…….. Active Controlled
46. Have you ever been taught how to control dental disease? No Yes
47. Have you ever had professional instructions on home care? No Yes
48. Do you have the time to participate in an active program of preventative maintenance? No Yes
49. Are you familiar with the term "preventative dentistry"? No Yes
50. Do you usually have many cavities? No Yes
51. Do you lose fillings or break fillings easily? No Yes
52. Do you have black fillings replaced due to washout, breakage or chipping? No Yes
53. Have you noticed any darkening of your metal fillings? No Yes
54. Do you now have, or are you aware that you have a latex allergy or sensitivity? No Yes
55. Do you normally receive numbing (local anesthetic) when you have dental work done? No Yes
56. Have you ever had difficulty getting numb with local anesthetics in conjunction with dental work? No Yes
57. Have you ever had Nitrous Oxide (laughing gas) with dental treatment? No Yes
58. Would you prefer to use Nitrous Oxide at your dental appointment time? No Yes
59. Do you gag easily? No Yes
60. Do you have difficulty in breathing through your nose? No Yes
61. Is your mouth completely comfortable? No Yes
62. Do you have time constraints related to have dental work completed? No Yes
    How can we better help you with you with the timing of your dental treatment in our office?
    _____
63. Are you interested in controlling you dental disease, or other dental problems? No Yes
64. Would you like to improve the appearance of your teeth and smile? No Yes
    What? _____
65. How much anxiety do you feel at the dentist?
    Very Much Moderately Somewhat Not at All

Masterpiece Family & Cosmetic Dentistry

Dental History

Patient Name:_____ Date:_____

66. How much pain have you experienced in previous dental treatment?
    Very Much Moderately Somewhat Not at All

67. How much have you neglected your dental treatment?
    Very Much Moderately Somewhat Not at All

68. To what degree has your past experience of pain affected your compliance with dental care?
    Very Much Moderately Somewhat Not at All

69. How often do you cancel or not appear for your dental appointments?
    Very Much Moderately Somewhat Not at All

70. Would you be interested in learning more about anxiety free dentistry? No Yes

71. Would you like to have all of your dental treatment done in as few appointments as possible? No Yes

72. How much have financial concerns affected your ability to have dental work completed in the past?
    None Some Occasionally Always

73. Do you now or have you had a lawsuit involving another dentist or health care provider? No Yes

74. Please make any comments or suggestions below so that my staff and I can make your dental appointments as pleasant as possible. _____

_____

_____

_____ _____ _____

Signature of Patient Date Signature of Doctor Date Signature Assistant/Hygienist