## **Dental History**

What is the reason for your visit today?  Date of Last Dental Visit Last Dental Cleaning Last X-Rays
Previous Dentist's Name How often do you brush your teeth? What other dental aids do you use? (Waterpik, toothpick, etc.) Do you have any dental problems now? Yes No Please describe: Are you satisfied with the appearance of your teeth? Yes No Do you feel nervous about dental treatment Yes No Would you biggest concern? Have you ever considered whitening your teeth? Yes No Would you like more information on whitening? Yes No Would you like to know if you are a good candidate for ortho? Yes No Are any of your teeth sensitive to? Hot or cold Yes No Snore or have other sleep disorders Yes No Sweets Yes No Have tired jaws especially in the morning Yes No Have you noticed any odor or bad tastes? Yes No Have you ever had? Do you frequently get cold sores, blisters, any other oral lesions? Yes No Periodontal treatment Yes No Too your gums hurt or bleed? Yes No Periodontal treatment Yes No Your teeth ground down or bite adjusted Yes No
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What other dental aids do you use? (Waterpik, toothpick, etc.)  Do you have any dental problems now? Yes No  Please describe:  Are you satisfied with the appearance of your teeth? Yes No  Do you feel nervous about dental treatment Yes No  If yes, what is your biggest concern?  Have you ever considered whitening your teeth? Yes No  Would you like more information on whitening? Yes No  Would you like to know if you are a good candidate for ortho? Yes No  Are any of your teeth sensitive to? Smoke/chew tobacco or use other products Yes No  Hot or cold Yes No Snore or have other sleep disorders Yes No  Biting or Chewing Yes No  Have you noticed any odor or bad tastes? Yes No  Have you noticed any odor or bad tastes? Yes No Have you ever had?  Do you frequently get cold sores, blisters, any other oral lesions? Yes No  Do your gums hurt or bleed? Yes No  Periodontal treatment Yes No  Your teeth ground down or bite adjusted Yes No
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Please describe:  Are you satisfied with the appearance of your teeth?  Are you satisfied with the appearance of your teeth?  Do you feel nervous about dental treatment  Yes No  If yes, what is your biggest concern?  Have you ever considered whitening your teeth?  Would you like more information on whitening?  Would you like to know if you are a good candidate for ortho?  Yes No  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Smoke/chew tobacco or use other products  Yes No  Hot or cold  Yes No  Snore or have other sleep disorders  Yes No  Have tired jaws especially in the morning  Yes No  Biting or Chewing  Yes No  Have you ever had?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No  Oral Surgery  Yes No  Periodontal treatment  Yes No  Your teeth ground down or bite adjusted  Yes No
Are you satisfied with the appearance of your teeth?  Do you feel nervous about dental treatment  Yes No  If yes, what is your biggest concern?  Have you ever considered whitening your teeth?  Would you like more information on whitening?  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Hot or cold  Yes No  Smoke/chew tobacco or use other products  Yes No  Sweets  Yes No  Have tired jaws especially in the morning  Yes No  Have you noticed any odor or bad tastes?  Yes No  Have you ever had?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No  Oral Surgery  Yes No  Periodontal treatment  Yes No  Your teeth ground down or bite adjusted  Yes No
Do you feel nervous about dental treatment  Yes No  If yes, what is your biggest concern?  Have you ever considered whitening your teeth?  Yes No  Would you like more information on whitening?  Yes No  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Smoke/chew tobacco or use other products  Yes No  Hot or cold  Yes No  Snore or have other sleep disorders  Yes No  Biting or Chewing  Yes No  Have tired jaws especially in the morning  Yes No  Have you noticed any odor or bad tastes?  Yes No  Have you ever had?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No  Oral Surgery  Yes No  Periodontal treatment  Yes No  Your teeth ground down or bite adjusted  Yes No
If yes, what is your biggest concern?  Have you ever considered whitening your teeth?  Would you like more information on whitening?  Yes No  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Hot or cold  Yes No Snore or have other sleep disorders  Yes No  Sweets  Yes No Have tired jaws especially in the morning  Yes No  Have you noticed any odor or bad tastes?  Yes No  Have you ever had?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No  Oral Surgery  Yes No  Periodontal treatment  Yes No  Yes No  Yes No  Yes No  Periodontal treatment  Yes No  Yes No  Yes No  Yes No  Yes No  Yes No  Oral Surgery  Yes No  Yes No  Yes No  Yes No  Yes No  Oral Surgery  Yes No  Yes No  Yes No  Yes No  Yes No  Oral Surgery  Yes No  Yes No  Yes No  Yes No  Oral Surgery  Yes No  Yes No  Oral Surgery  Yes No
Have you ever considered whitening your teeth?  Would you like more information on whitening?  Yes No  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Hot or cold Yes No Snore or have other sleep disorders Yes No  Sweets Yes No Have tired jaws especially in the morning Yes No  Biting or Chewing Yes No  Have you noticed any odor or bad tastes? Yes No  Have you noticed any odor or bad tastes? Yes No Orthodontic treatment  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No Oral Surgery  Yes No  Periodontal treatment  Yes No  Your teeth ground down or bite adjusted  Yes No
Would you like more information on whitening?  Would you like to know if you are a good candidate for ortho?  Yes No  Are any of your teeth sensitive to?  Hot or cold Yes No Snore or have other sleep disorders Yes No  Sweets Yes No Have tired jaws especially in the morning Yes No  Biting or Chewing Yes No  Have you noticed any odor or bad tastes? Yes No  Have you ever had?  Do you frequently get cold sores, blisters, orthodontic treatment Yes No  any other oral lesions? Yes No Oral Surgery Yes No  Do your gums hurt or bleed? Yes No  Your teeth ground down or bite adjusted Yes No
Would you like to know if you are a good candidate for ortho?  Are any of your teeth sensitive to?  Hot or cold  Yes  No  Smoke/chew tobacco or use other products  Yes  No  Snore or have other sleep disorders  Yes  No  Sweets  Yes  No  Have tired jaws especially in the morning  Yes  No  Have you noticed any odor or bad tastes?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes  No  Oral Surgery  Yes  No  Periodontal treatment  Yes  No  Yes  No  Yes  No  Yes  No  Periodontal treatment  Yes  No  Yes
Are any of your teeth sensitive to?  Hot or cold  Yes  No  Smoke/chew tobacco or use other products  Yes  No  Have tired jaws especially in the morning  Yes  No  Have you ever had?  Orthodontic treatment  Yes  No  Oral Surgery  Yes  No  Periodontal treatment  Yes  No
Hot or cold  Yes No Snore or have other sleep disorders  Yes No Have tired jaws especially in the morning  Yes No Have you noticed any odor or bad tastes?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No Oral Surgery  Yes No Oral Surgery  Yes No Yes No Yes No Yes No Yes No Yes No Your teeth ground down or bite adjusted
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Biting or Chewing  Have you noticed any odor or bad tastes?  Do you frequently get cold sores, blisters, any other oral lesions?  Yes No Oral Surgery  Yes No Oral Surgery  Yes No Oral Surgery  Yes No Your teeth ground down or bite adjusted  Yes No Your teeth ground down or bite adjusted
Do you frequently get cold sores, blisters, any other oral lesions?  Yes No Oral Surgery  Yes No  Do your gums hurt or bleed?  Yes No  Periodontal treatment  Yes No  Your teeth ground down or bite adjusted  Yes No
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Do your gums hurt or bleed?  Yes No  Periodontal treatment  Your teeth ground down or bite adjusted  Yes No
Your teeth ground down or bite adjusted Yes No
Have your parents experienced gum A bite plate or mouth guard Yes No
Thave your parents experienced gain.
disease or tooth loss?  Yes No A serious injury to the mouth or head Yes No
Have you noticed any loose teeth or If yes, please describe
change in your bite? Yes No
Does food tend to become caught in  between your teeth?  Yes No Have you experienced?
between your teeth? Yes No Have you experienced?  If yes, where? Clicking or popping of the jaw Yes No
Pain in the jaw joint or ear Yes No
Do You? Difficulty in opening or closing your mouth Yes No
Mouth breathe while awake or asleep  Yes No Difficulty in chewing on either side
Clench or grind your teeth while of your mouth Yes No
awake or asleep? Yes No Headaches or neckaches Yes No
Bite your lips or cheeks regularly  Yes No Sore shoulder muscles  Yes No
Hold foreign objects with your teeth
(Pencils, pipe, pins, nails, fingernails) Yes No
Is there anything else about having dental treatment you would like us to know? Yes No
If yes, please describe?