Patient Forms

Dental History

Referred by: ____

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

Previous Dentist: __________________________________

How long have you been a patient (month/years)? ____________________________

Date of most recent dental exam: _____/_____/_____

Date of most recent x-rays: _____/_____/_____

Date of most recent treatment (other than cleaning): _____/_____/_____

I routinely see my dentist every: ☐ 3 months, ☐ 4 months, ☐ 6 months, ☐ 12 months, ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY:		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very): _____________	☐	☐
2. Have you ever had an unfavorable dental experience? ________________	☐	☐
3. Have you ever had complications from past dental treatment ____________	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ____	☐	☐
6. Have you ever had any teeth removed? _________________________	☐	☐
SMILES CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth? ______________________	☐	☐
9. Are you self-conscious about your teeth? ___________________________	☐	☐
10. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
11. Do you/would you have any problems chewing gum? ____________________	☐	☐
12. Do you/would you have any problems chewing bagels or other hard foods? _____	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ____	☐	☐
14. Are your teeth crowding or developing spaces? _______________________	☐	☐
15.Do you have more than one bite or do you clench to make your teeth fit together? __	☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, locking) ___________	☐	☐

Call today 561-844-0715 | 4600 Military Trail #219 | Jupiter, FL 33458