Dental History

MAPLEWOOD DENTAL ARTS
providing a lifetime of healthy smiles

Andrea M. Taliento, DMD
Melissa M. Carrier, DDS

PATIENT INFORMATION

Name_____ Date _____

PREVIOUS DENTIST

How long were you a patient? _____ Months/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 mo. 4 mo. 6 mo. 12 mo. Not routinely

PERSONAL HISTORY

How would you rate the condition of your mouth? Excellent Good Fair Poor
What is your immediate concern? _____
Are you fearful of dental treatment? Scale of 1-10(very) 1 2 3 4 5 6 7 8 9 10
Have you had an unfavorable dental experience? ..... Yes No
Have you ever had complications from past dental treatment? ..... Yes No
Have you ever had trouble getting numb or reactions to local anesthetic?..... Yes No
Did you ever have braces, orthodontic treatment or had your bite adjusted? ..... Yes No
Have you had any teeth removed? ..... Yes No

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?..... Yes No
Have you ever whitened (bleached) your teeth? ..... Yes No
Are you self-conscious about your teeth? ..... Yes No
Have you been disappointed with the appearance of previous dental work?..... Yes No
Comments _____
_____

BITE AND JAW JOINT

Do you, would you have any problems chewing gum?..... Yes No
Do you, would you have any problems chewing bagels or other hard foods?..... Yes No
Have your teeth changed in the last 5 years, become shorter, thinner or worn? ..... Yes No
Are your teeth crowding or developing spaces? ..... Yes No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?..... Yes No
Do you have any problems with sleep or wake up with an awareness of your teeth?..... Yes No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ..... Yes No
Do you have tension headaches or sore teeth? ..... Yes No
Do you wear or have you ever worn a bite appliance? ..... Yes No

TOOTH STRUCTURE

Have you had any cavities within the past 3 years? ..... Yes No
Do you have a dry mouth? ..... Yes No
Are any teeth sensitive to hot, cold, biting or sweets? ..... Yes No
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?..... Yes No
Do you avoid brushing any part of your mouth? ..... Yes No

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GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?	Yes	No
Have you ever experienced gum recession?	Yes	No
Is there anyone with a history of periodontal disease in your family?	Yes	No
Do your gums bleed when brushing, flossing or eating?	Yes	No
Are your teeth becoming loose?	Yes	No
Have you ever noticed an unpleasant taste or odor in your mouth?.....	Yes	No
Have you experienced a burning sensation in your mouth?	Yes	No

Doctor's Signature _____ Date _____