BOTOX onabotulinumtoxinA Juvéderm invisalign

PHOENIXVILLE DENTAL

DENTAL HISTORY

Patient Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____ Maritial Status _____

Referred by _____ 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 dental exam____/____/_____ Date of most recent x-rays____/____/_____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ○ 3 mo. ○ 4 mo. ○ 6 mo. ○ 12 mo. ○ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	○	○
2. Have you had an unfavorable dental experience? _____	○	○
3. Have you ever had compications from past dental treatment? _____	○	○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	○	○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	○	○
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	○	○

GUM AND BONE	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing? _____	○	○
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	○	○
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	○	○
10. Is there anyone with a history of periodontal disease in your family? _____	○	○
11. Have you ever experienced gum recession? _____	○	○
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	○	○
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	○	○

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	○	○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	○	○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	○	○
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	○	○
18. Do you have grooves or notches on your teeth near the gum line? _____	○	○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	○	○
20. Do you frequently get food caught between any teeth? _____	○	○

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	○	○
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	○	○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry food? _____	○	○
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	○	○
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	○	○
26. Are your teeth developing spaces or becoming more loose? _____	○	○
27. Do you have trouble finding your bite or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	○	○
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	○	○
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	○	○
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	○	○
32. Do you wear or have you ever worn a bite appliance? _____	○	○

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	○	○
34. Have you ever whitened (bleached) your teeth? _____	○	○
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	○	○
36. Have you been disappointed with the appearance of previous dental work? _____	○	○

Patient's Signature _____ Doctor's Signature _____ Date _____