VALENCIA DENTAL OFFICE

Dental History

Patient Details

First Name

Last Name

How would you rate the condition of your mouth?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Name of your previous dentist

Date of most recent dental exam

I routinely see my dentist every:

- ◯ 3 months
- ◯ 4 months
- ◯ 6 months
- ◯ 12 months
- ◯ Not routinely

What is your immediate concern?

Are you fearful of dental treatment?

- ◯ Yes
- ◯ No

Have you had an unfavorable dental experience?

- ◯ Yes
- ◯ No

Have you ever had complications from your past dental treatment?

- ◯ Yes
- ◯ No

Have you ever had trouble getting numb or had any reactions to local anesthetic?

- ◯ Yes
- ◯ No

Did you ever have braces, orthodontic treatment ?

- ◯ Yes
- ◯ No

Do your gums bleed or are they painful when brushing or flossing?

- ◯ Yes
- ◯ No

Have you ever been treated for gum disease or been told you have lost bone around your teeth?

- ◯ Yes
- ◯ No

Bad breath?

- ◯ Yes
- ◯ No

Have you experienced a burning sensation in your mouth?

- ◯ Yes
- ◯ No

Tooth Structure

Have you had any cavities within the past 3 years?

- ◯ Yes
- ◯ No

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?

- ◯ Yes
- ◯ No

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?

◯ Yes ◯ No

Loose teeth or broken fillings?

◯ Yes ◯ No

Do you frequently get food caught between any teeth?

◯ Yes ◯ No

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)

◯ Yes ◯ No

Are your teeth becoming more crooked, crowded, or overlapped?

◯ Yes ◯ No

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?

◯ Yes ◯ No

Do you Clench/Grind at night

◯ Yes ◯ No

Do you wear or have you ever worn a bite appliance?

◯ 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

Have you felt uncomfortable or self conscious about the appearance of your teeth?

◯ Yes ◯ No

Have you been disappointed with the appearance of previous dental work?

◯ Yes ◯ No

Patient E-Signature (draw, upload or type)

Date

Date: