# Sierra Crest Dental
## Dental History

Rerferred 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: ❒ 3months ❒ 4 months ❒ 6 months ❒ 12 months ❒ 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? Scale of 1 to 10 (very) __ | ❒ | ❒ |
| 2. Have you 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. Have you ever had braces, orthodontic treatment or had your bite adjusted? | ❒ | ❒ |
| 6. Have you had any teeth removed? | ❒ | ❒ |
| **SMILE CHARACTERISTICS** | | |
| 7. Is there anything about the appearance of your teeth that you would like to change? | ❒ | ❒ |
| 8. Have you ever whitened (bleach) 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 the one bite or do you clench (squeeze) 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, limited opening, locking, popping) | ❒ | ❒ |
| 18. Do you have tension headaches or sore teeth? | ❒ | ❒ |
| 19. Do you wear or have you ever worn a bite appliance? | ❒ | ❒ |
| **TOOTH STRUCTURE** | | |
| 20. Have you had any cavities within the past 3 years? | ❒ | ❒ |
| 21. Do you have a dry mouth? | ❒ | ❒ |
| 22. Are any teeth sensitive to hot, cold, biting, or sweets? | ❒ | ❒ |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? | ❒ | ❒ |
| 24. Do you avoid brushing any part of your mouth? | ❒ | ❒ |
| **GUM AND BONE** | | |
| 25.Have you ever been diagnosed or treated for periodontal (gum) disease? | ❒ | ❒ |
| 26. Have you ever experienced gum recession? | ❒ | ❒ |
| 27. Is there anyone with a history of periodontal disease in your family? | ❒ | ❒ |
| 28. Do your gums bleed when brushing, flossing or eating? | ❒ | ❒ |
| 29. Are your teeth becoming loose? | ❒ | ❒ |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? | ❒ | ❒ |
| 31. Have you ever experienced a burning sensation in your mouth | ❒ | ❒ |

Patient's Signature _____ Date _____

Doctor's Signature _____