Dexter Dental Studio Dental History *Name*_____ *Date*_____

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

Most recent dental visit: _____/_____/_____ Most recent X-rays: _____/_____/_____

How often have you routinely seen your dentist?

Every 3 months Every 4 months Every 6 months Every 12 months Not routinely

*Please **Circle** if you have or have had in the past*

PERSONAL HISTORY

1. On a scale of 1-10, how important is it for you to keep your teeth? _____
2. Have you ever had teeth removed (extracted)?
3. Do you have dental implants?
4. Did you ever have braces or orthodontic treatment?
5. Do you have partials or dentures? If yes, are you satisfied with the fit? _____

SMILE CHARACTERISTICS

6. On a scale of 1-10, how would you rank the appearance of your smile? _____
7. Have you ever whitened (bleached) your teeth?
8. Are you self-conscious about your teeth?

BITE & JAW JOINT

9. Do you have any problems chewing bagels or other hard foods?
10. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
11. Are your teeth crowding or developing spaces?
12. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together?
13. Do you have any problems with sleep in general, or wake up with an awareness of your teeth?
14. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?
15. Do you have tension headaches or sore teeth?
16. Do you wear, or have you ever worn, a bite appliance?

TOOTH STRUCTURE

17. Do you consider yourself cavity prone?
18. Do you have any sugar habits such as pop, juice, sports drinks, candy or gum?
19. Do you have a dry mouth?
20. Are any teeth sensitive to hot, cold, biting or sweets?
21. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth?
22. Do you avoid brushing any part of your mouth?

GUM & BONE

23. Have you ever been diagnosed or treated for periodontal (gum) disease?
24. Have you ever experienced gum recession?
25. Is there anyone with a history of periodontal disease in your family?
26. Do your gums bleed when brushing, flossing or eating?
27. Are your teeth becoming loose?
28. Have you ever noticed an unpleasant taste or odor in your mouth?

Please share with us any other goals or ideas you may have about your oral health or appearance of your smile:

Provider Intl:_____