Barnstable Dental Associates

15 Cedar Street, Hyannis MA 02601

Dental History

Patient Name:_____ Date:_____

Why have you come to the dentist today?_____

Who was your previous dentist?_____

When was the last time you saw a dentist?_____

When was your last dental cleaning?_____

Y	N	Are you currently experiencing pain?
Y	N	Have you ever had a serious problem with prior dental treatment?
Y	N	Do you have a fear of dental treatment?
Y	N	Do you have a fear of needles?
Y	N	Has fear caused a delay or avoidance of dental treatment?
Y	N	Have you ever seen a Periodontist or had gum treatment/ surgery?
Y	N	Have you had any problems with your jaw joint (TMJ/TMD)?
Y	N	Do you wear a removable partial or full denture?
Y	N	Do you wear a nightguard/ sportsguard/ retainer? (please circle)
Y	N	Do you floss? How often?_____
Y	N	Do you use an electric tooth brush?
Y	N	Do you snore?
Y	N	Are you aware of grinding or clenching your teeth during day or night?
Y	N	Have you been diagnosed with sleep apnea?

If you are using a regular toothbrush, what type of bristles? Hard Medium Soft

Anything about the APPEARANCE of your teeth that you are not happy with:_____
_____

Anything about the way your teeth FUNCTION that you are not happy with:_____
_____