Clifton Park Dental
Your family dentists in Clifton Park, NY

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DENTAL HISTORY

NAME: _____ **BIRTHDATE:** _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of most recent dental exam _____ Date of most recent X-ray _____
Date of most recent treatment other than a cleaning _____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
Have you had an unfavorable dental experience?	○	○
Have you ever had complications from past dental treatment?	○	○
Have you ever had trouble getting numb or had any reactions to local anesthetics?	○	○
Did you ever have braces, orthodontic treatment or had your bite adjusted?	○	○
SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change?	○	○
Have you ever whitened (bleached) your teeth?	○	○
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	○	○
Have you been disappointed with the appearance of previous dental work?	○	○
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
Have your teeth changed in the last 5 years, becoming shorter, thinner, or worn?	○	○
Are your teeth crowding or developing spaces?	○	○
Do you have more than one bite and squeeze to make your teeth fit together?	○	○
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
Do you clench your teeth in the daytime or make them sore?	○	○
Do you have any problems with sleep or wake up with an awareness of your teeth?	○	○
Do you wear or have you ever worn a bite appliance?	○	○
TOOTH STRUCTURE		
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	○	○
Do you have grooves or notches on your teeth near the gum line?	○	○
Do you frequently get food caught between any teeth?	○	○
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
GUM AND BONE		
Do your gums bleed or are they painful when brushing or flossing?	○	○
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	○	○
Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
Is there anyone with a history of periodontal disease in your family?	○	○
Have you ever experienced gum recession?	○	○
Have you ever had any teeth become loose on their own (without an injury)?	○	○
Have you experienced a burning sensation in your mouth?	○	○

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____