DENTAL HISTORY

Mint Dental

First Name _____ Last Name _____ MI _____

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

Who was your previous dentist? _____ What was done at that time? _____

Date of last dental exam? _____ Date of last dental x-rays _____

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern? _____

	Yes	No
PERSONAL HISTORY		
Are you fearful of dental treatment?	☐	☐
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?	☐	☐
Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
Have you ever whitened your teeth?	☐	☐
BITE AND JAW JOINT		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
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 wear or have every worn a bite appliance?	☐	☐

	Yes	No
TOOTH STRUCTURE		
Have you had any cavities within the past 3 years?	☐	☐
Do you have difficulty swallowing any food?	☐	☐
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 avoid brushing any part of your mouth?	☐	☐
Do you have grooves or notches on your teeth near the gumline?	☐	☐
Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?	☐	☐
Do you get food caught between any teeth?	☐	☐
GUM AND BONE		
Do your gums bleed when brushing or flossing?	☐	☐
Have you ever been treated for gum disease?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
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?	☐	☐
Do you wish to keep all your teeth?	☐	☐
Has a dentist ever recommended that you take antibiotics prior to dental treatment?	☐	☐

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

FOR COMPLETION BY DENTIST

Comments: _____

_____

PROVIDER SIGNATURE _____ *DATE* _____