THIRD STREET DENTAL
DR. MELISSA SKINNER

DENTAL HISTORY

Previous Dentist(or office)_____ How long have you been a patient?_____Month/Years
Date of most recent dental exam_____ Date of last hygiene/cleaning appointment) _____
Date of most recent x-rays? _____
What is your immediate concern?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) [_____]_____ □ □
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 had any reactions to local anaesthetic? _____ □ □
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ □ □
6. Have you had any teeth removed?_____ □ □

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?_____ □ □
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ □ □
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____ □ □
10. Is there anyone with a history of periodontal disease in your family?_____ □ □
11. Have you ever experienced gum recession?_____ □ □
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?_____ □ □
13. Have you experienced a burning sensation in your mouth? _____ □ □

TOOTH STRUCTURE

14. Have you had any cavities within the last 3 years?_____ □ □
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____ □ □
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____ □ □
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing in any part of your mouth?_____ □ □
18. Do you have any grooves or notches on your teeth near the gumline? _____ □ □
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ □ □
20. Do you frequently get food caught between any teeth? _____ □ □

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ □ □
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____ □ □
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____ □ □
24. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____ □ □
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ □ □
26. Are your teeth developing spaces or becoming loose? _____ □ □
27. Do you have more than one bite, or squeeze/shift your jaw to make your teeth fit together? _____ □ □
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ □ □
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ □ □
30. Do you clench your teeth in the daytime or make them sore? _____ □ □
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?_____ □ □
32. Do you wear or have you ever worn a bite appliance? _____ □ □

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth you would like to change?_____ □ □
34. Have you ever whitened (bleached) or teeth? _____ □ □
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ □ □
36. Have you been disappointed with the appearance of previous dental work?_____ □ □

DATE **PRINT NAME** **SIGNATURE: PATIENT ( ) PARENT ( ) GUARDIAN ( )**