Family Dentistry of Texoma

WHAT IS YOUR IMMEDIATE CONCERN: _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Personal History

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	YES	NO
2. Have you had an unfavorable dental experience?	YES	NO
3. Have you ever had complications from past dental treatment?	YES	NO
4. Have you ever had trouble getting numb or reaction to local anesthetic?	YES	NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	YES	NO
6. Have you had any teeth removed?	YES	NO

Smile Characteristics

7. Is there anything about your appearance of your teeth that you would like to change?	YES	NO
8. Have you ever whitened (bleached) your teeth?	YES	NO
9. Are you self conscious about your teeth?	YES	NO
10. Have you been disappointed with the appearance of previous dental work?	YES	NO

Bite and Jaw Joint

11. Do you/would you have any problems chewing gum?	YES	NO
12. Do you/would you have any problems chewing bagels or other hard foods?	YES	NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	YES	NO
14. Are your teeth crowding or developing spaces?	YES	NO
15. Do you have more than one bite or do you clench to make your teeth fit together?	YES	NO
16. Do you have problems with sleep or wake up with an awareness of your teeth?	YES	NO
17. Do you have any problems with your jaw joint? (pain, limited opening, locking, popping)	YES	NO
18. Do you have more tension headaches or sore teeth?	YES	NO
19. Do you wear or have you ever worn a bite appliance?	YES	NO

Tooth Structure

20. Have you had any cavities within the past 3 year?	YES	NO
21. Do you have a dry mouth?	YES	NO
22. Are any teeth sensitive to hot, cold, biting or sweets?	YES	NO
23. Have you ever had a toothache, cracked filing, broken, chipped or cracked tooth?	YES	NO
24. Do you avoid brushing any part of your mouth?	YES	NO

Gum and Bones

25. Have you ever been diagnosed or treated for periodontal (gum) disease?	YES	NO
26. Have you ever experienced gum recession?	YES	NO
27. Is there anyone with a history of periodontal disease in your family?	YES	NO
28. Do your gums bleed when brushing, flossing or eating?	YES	NO
29. Are your teeth becoming loose?	YES	NO
30. Have you ever noticed an unpleasant taste or odor in your mouth?	YES	NO
31. Have you experienced a burning sensation in your mouth?	YES	NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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