NP - Dental History

Dental History

First Name - Patient *

Last Name - Patient *

Patient Date of Birth

Why are you changing your dentist?

How long ago was your last visit to the dentist?

- ~ 6 months
- Less than 1 year
- 1-3 year
- More than 3 year
- I've never seen a dentist

Name and phone number of previous dentist:

Date of most recent dental exam if you know it

How did you find us?

- Other Patient
- Friend/Collegue
- Google
- Internet
- Next Door App
- Other

I routinely see my dentist every:

- 3 Months
- 4 Months
- 6 Months
- 12 Months
- Not Routinely

Reason for today's visit:

- Check-up
- Pain
- Other

What is your immediate dental concern?

Have you ever had a bad experience at the dentist?

- Yes
- No

Have you had any complications following treatment?

○ Yes ○ No

Have you had any unfavorable reactions to dental anesthetic?

○ Yes ○ No

Are your teeth sensitive to cold or hot temperatures? ○ Yes ○ No	Do you grind your teeth? ○ Yes ○ No
Are you aware of sores or irritated areas in the mouth? ○ Yes ○ No	Have you ever been treated for Periodontal or Gum Disease? ○ Yes ○ No
Does dental treatment make you nervous? ○ No ○ Slightly ○ Moderately ○ Extremely	Do your gums bleed when you brush or floss? ○ Yes ○ No ○ Sometime
How often do you brush? ○ Never ○ Occasionally ○ Once a day ○ Twice a day ○ Every time I eat	What type of brush do you use? ○ Manual ○ Electric ○ Both
How often do you floss? ○ Never ○ Occasionally ○ Once a day ○ More than Once a day	How would you rate the condition of your mouth? ○ Poor ○ Good ○ Excellent

Check all that apply:

- ☐ Had trouble getting numb
- ☐ Had/have experienced dry mouth
- ☐ Have experience popping and/or clicking of the jaw joint Or can't open wide
- ☐ Experienced gum recession
- ☐ Notice teeth becoming more crooked Or crowded Or overlapped
- ☐ Have any teeth sensitive to biting Or sweets Or avoid brushing any part of the mouth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance or night guard
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Notice spaces developing between teeth
- ☐ Had/have braces Or orthodontic treatment
- ☐ Food gets trapped between any teeth
- ☐ Have whitened or bleached your teeth
- ☐ Clench or grind your teeth
- ☐ Noticed an unpleasant taste or odor in your teeth
- ☐ Experienced a burning sensation in the mouth
- ☐ Snore or wake up frequently during the night

Your Smile:

Do you like your smile?

○ Yes ○ No

If you could change your smile, what would you like to change?

- ☐ Change the color of my teeth
- ☐ Change the position or alignment of my teeth
- ☐ Close spaces or restore worn out or broken teeth
- ☐ Change the shape of my teeth
- ☐ Other

I am interested in:

- ☐ Teeth whitening
- ☐ Straight teeth
- ☐ Replacement of missing teeth
- ☐ White fillings
- ☐ Other

To ensure your visit is a great experience, please share any questions or concerns you would like us to know about: