Broadway Smiles
EXCEPTIONAL DENTISTRY

DENTAL HISTORY

Name: _____ BirthDate: _____

What is the reason for your visit today? _____

Last Dental Cleaning: _____ Last Dental Visit: _____

Last Routine 4-BW X-rays: _____ Last Full Mouth X-rays: _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name: _____

Address: _____ State: _____ Zip: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (waterpick, electric toothbrush, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No
Sweet? ☐ Yes ☐ No
Biting or Chewing? ☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss ☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No
Mouth breathe while awake or asleep? ☐ Yes ☐ No
Have tired jaws, expecially in the morning? ☐ Yes ☐ No
Snore or have any other sleeping disorders? ☐ Yes ☐ No
Smoke/Chew tobacco or use other tobacco products? (marijuana) ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Pediodontal treatment? ☐ Yes ☐ No
Your teeth ground or bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause: _____

Have you ever experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain? (joint, ear, side of face) ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of mouth? ☐ Yes ☐ No
Headaches, neckaches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders)? ☐ Yes ☐ No
Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No
Are you apprehensive about dental treatment? ☐ Yes ☐ No

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

- Fear of Pain: _____
- Cost of Treatment: _____
- Lack of Concern: _____
- Missing work time: _____

If you could change anything about your smile it would be:

☐ Make them brighter
☐ Close spaces
☐ Repair chipped teeth
☐ Alterative to a denture
☐ Get a smile makeover
☐ Make them straighter
☐ Replace metal fillings with tooth color fillings
☐ Replace missing teeth
☐ Replace old crowns that don't match
☐ Nothing, I love it.

On a scale of 1-10, with 1- being the highest

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe: _____

_____