Stone Creek
DENTAL CARE

DENTAL HISTORY

NAME_____

Previous Dentist_____ For how long?_____

Please circle your answer:
When was your last dental exam? 1-3 months 4-6 months 6-12 months 1-2 years 2+ years

How often do you have your teeth cleaned? *Every:* 3 months 4 months 6 months 1 year or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

❑yes ❑no Are you self-conscious of your teeth and/or smile?
❑yes ❑no Do you like the color of your teeth?
❑yes ❑no Do you have spaces between your teeth that bother you?
❑yes ❑no Do you have chips or uneven edges on your teeth?
❑yes ❑no Do you feel that your teeth are too long or too short?
❑yes ❑no Do you have dark fillings that show when you smile?
❑yes ❑no Do you avoid brushing any part of your mouth?
❑yes ❑no Is any part of your mouth sensitive to temperature?
❑yes ❑no Do you have sore teeth?
❑yes ❑no Any burning sensation in your mouth?
❑yes ❑no Bleeding gums?
❑yes ❑no Difficulty swallowing?
❑yes ❑no An unpleasant taste or odor in your mouth?
❑yes ❑no Dry mouth, throat and/or eyes?
❑yes ❑no Jaw problems (temporomandibular joint)

❑yes ❑no Do you have difficulty opening your mouth widely?
❑yes ❑no Stiff neck muscles
❑yes ❑no Tension headaches
❑yes ❑no Do you clench or grind your teeth?
❑yes ❑no Do you experience jaw clicking or popping?
❑yes ❑no Have you lost any teeth?
❑yes ❑no Have you had an unfavorable dental experience?
❑yes ❑no Do you have dental fears?
❑yes ❑no Problems with effectiveness or bad reactions to dental anesthetic
❑yes ❑no Have you had periodontal (gum) treatment
If yes, when? _____
❑yes ❑no Have you had orthodontic treatment (braces)
If yes, when?_____
❑yes ❑no Do you sweat or tremble a lot during an exam?
❑yes ❑no Do strange/unknown people or places make you afraid?

Is there anything else that you would like us to be aware of regarding your oral health?
_____
_____

What sports do you participate in?_____
Where do you get your water supply from?_____City_____Own well_____Bottled

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:
Has your present denture been relined? When_____
Is your present denture a problem? Explain_____
Satisfied with the appearance?____ Satisfied with the comfort?____ Satisfied with the chewing ability?____
When did you receive your first partial or complete denture?_____
How long have you worn your present denture?_____

PATIENT'S SIGNATURE_____DATE_____

DOCTOR'S SIGNATURE _____DATE_____