Dental History Form

CANNON
FAMILY DENTISTRY

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

General Information

Who was your previous Dentist and how long were you a patient there?

Date of your last dental exam

Do you have any immediate concerns you'd like us to address?

Date of your last cleaning

Office Relationship

What do you value most in your dental visits?

Is there anything you prefer during your visits to make you more comfortable during your time with us?

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?

Personal History

Please answer the following questions

Are you concerned about the appearance of your teeth?	Y	N	Have you had any cavities within the past 2 years?	Y	N
Are you interested in improving your smile?	Y	N	Do you clench your teeth in the daytime?	Y	N
Are any teeth currently sensitive to biting, sweets, hot, or cold?	Y	N	Do you avoid or have difficulty chewing or biting heavily any hard foods?	Y	N
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	Y	N	Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	Y	N

Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? Y N

Have you ever noticed a consistently unpleasant taste or odor in your mouth? Y N

Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often? Y N

Dental Structural History

Please answer the following questions

Do your gums bleed when brushing or flossing? Y N

Is brushing or flossing typically painful? Y N

Have you ever experienced or been told you have gum recession? Y N

Have you ever been treated for or been told you have gum disease? Y N

Have you had any teeth removed for braces or otherwise? Y N

Do you know of any missing teeth or teeth that have never developed? Y N

Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" Y N

Are your teeth becoming more crowded, overlapped, or "crooked?" Y N

Are your teeth developing spaces? Y N

Do you frequently get food caught between any teeth? Y N

Have you noticed your teeth becoming shorter, thinner, or flatter over the years? Y N

Is it often difficult to open wide? Y N

Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?) Y N

Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together? Y N

Patient's Signature | Date

Doctor's Signature | Date