PRISTINE PERIODONTICS AND IMPLANTS

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DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____–__ How long have you been a patient?_____

Months/Years/Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth?	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
10 Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
12. Do you / would you have any problems chewing gum?	☐	☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods?	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
15. Are your teeth crowding or developing spaces?	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
18. Do you clench your teeth in the daytime or make them sore?	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
20. Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years?	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
25. Do you have grooves or notches on your teeth near the gum line?	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
27. Do you get food caught between any teeth?	☐	☐
GUM AND BONE		
28. Do your gums bleed when brushing or flossing?	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Is there anyone with a history of periodontal disease in your family?	☐	☐
32. Have you ever experienced gum recession?	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
34. Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature_____Date_____

Doctor's Signature _____Date _____

Send completed form to: frontdesk@pristineperioimplants.com