SUMMIT FAMILY DENTISTRY
275 NORTH HIGHWAY 16 #101
DENVER, NC 28037
(980) 222-7501
www.summitfamilydentist.com

Dental History

Patient Name: _____ Date of Birth: _____

General Information

Who was your previous Dentist and how long were you a patient there? _____
Date of your last dental examination_____
Date of your last dental cleaning _____
Do you have any immediate concerns you'd like us to address?
_____

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? 1 2 3 4 5

Personal History

Please answer the following questions

Are you concerned about the appearance of your teeth? _____
Are you interested in improving your smile? _____
Have you had any cavities within the past 2 years? _____
Are any of your teeth currently sensitive to biting, sweets, hot, or cold? _____
Do you avoid or have difficulty chewing or biting heavily on any hard foods? _____
Do you have any problems sleeping, waking up with a headache or with sore or sensitive teeth?
_____
Do you clench your teeth in the daytime? _____
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea? _____
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?_____
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?
_____
Have you ever noticed a consistently unpleasant taste or odor in your mouth?
_____

Dental Structural History

Please answer the following questions

Do your gums bleed when brushing or flossing? _____
Is brushing or flossing typically painful? _____
Have you ever experienced or been told you have gum recession? _____
Have you ever been treated for or been told you have gum disease? _____
Have you had any teeth removed for braces or otherwise? _____
Do you know of any missing teeth or teeth that have never developed? _____
Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" _____

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

Are your teeth developing spaces? _____
Do you frequently get food caught between your teeth? _____
Have you noticed your teeth becoming shorter, thinner, or flatter over the years? _____
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?) _____
Is it often difficult to open wide? _____
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together? _____

Patient Signature: _____
Date of Signature: _____