ALLISON
& ASSOCIATES

DENTAL HISTORY:

Patient Name:_____

DOB:_____

We want to give you the best dental experience and to do so we need to learn some of your preferences. We truly feel no two patients are the same and what better way to get to know you than to ask!

When was your last dental exam/cleaning?_____
Previous or Referring Dentist's Office:_____
Phone:_____**Email:**_____
Address:_____
City:_____**State:**_____**Zip:**_____

What is the primary reason for your dental visit today (circle all that apply)?

- **Routine dental care**
- **I know I have dental problems which need restoration**
- **Prevention of future problems**
- **Cosmetics/appearance of my smile**
- **Pain**
- **Elimination of infection/odor**
- **Missing teeth**
- **Desire to chew better**
- **General health**
- **My spouse/parent made me come**
- **Second opinion**
- **I am experiencing dry mouth**
- **I have been told I snore and/or stop breathing at night**

My teeth are sensitive to: hot, cold, sweets, chewing

My gums bleed with flossing and brushing. Yes/No

Have you noticed loose teeth or shifting teeth? Yes/No

Do you clench/grind your teeth? Yes/No

Do you wear a bite splint when sleeping? Yes/No

Are your teeth worn with square edges? Yes/No

Do your jaw muscles ache? Yes/No When?_____

Does your jaw click or pop? Yes/No Any pain? Yes/No

Have you had orthodontic treatment? Yes/No When?_____

Have you been told you have gum disease and/or been treated by a periodontist? Yes/No

Have you had a deep cleaning? Yes/No

Have you been told you snore? Yes/No

Do you suffer from dry mouth? Yes/No When do you notice it? Morning/Day/Night

Have you seen an oral surgeon before? Yes/No For which procedure?_____

Describe your dental mindset (circle phrases that apply):

- **My mouth feels good./My mouth is uncomfortable.**
- **I love my smile!/I hate my smile!**
- **Keeping my teeth is a high priority./I don't care if I have dentures.**
- **Dental care is part of my general wellness./My mouth is not representative of my general health.**
- **My daily dental routine is excellent!/I brush but rarely floss.**
- **I prefer long-lasting solutions./I want a quick fix.**
- **I am willing to make an investment into my dental health./I will only fix teeth if I have pain.**
- **I let my dentist guide me as to what is best for my dental health./ I will only do treatment if covered by dental insurance.**

<u>Oral Hygiene Routine:</u>

- **What do you use to care for your teeth?_____**
- **How often do you care for your teeth?_____**

<u>I have the following general concerns about dental treatment (circle all that apply):</u>

- **Anxiety/fear**
- **Pain**
- **Money/Cost**
- **Time**
- **Lack of trust due to previous experiences**

I AUTHORIZE THE DENTISTS AND STAFF TO PERFORM DENTAL TREATMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION TO DENTAL SPECIALISTS TO PROVIDE FOR DENTAL CARE AND TREATMENT OR TO MEDICAL PERSONNEL IN CASE OF A MEDICAL EMERGENCY.

PATIENT NAME:_____
PATIENT SIGNATURE:_____
DATE:_____
DENTIST REVIEW DATE AND SIGNATURE:_____