2000 yonge Dental | Dental History Information

Last Name _____ First Name _____

Previous Dentist _____ How long were you a patient (months/years)? _____

Most recent dental exam DAY MO YEAR Most recent X-rays DAY MO YEAR

Most recent treatment (other than a cleaning) DAY MO YEAR

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

How would you describe the overall condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate dental concern? _____

Please check if your answer is YES to any of the following questions:

Personal History

1. ☐ Are you fearful of dental treatment?
   How fearful, on a scale of 1 (least) to 10 (most) _____
2. ☐ Have you ever had an unfavourable dental experience?
3. ☐ Have you ever had complications from past dental treatment?
4. ☐ Did you ever have braces, orthodontic treatment or had your bite adjusted?

Smile Characteristics

5. ☐ Is there anything about the appearance of your teeth that you would like to change?
6. ☐ Have you ever whitened (bleached) your teeth?
7. ☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint

8. ☐ Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?
9. ☐ Have your teeth changed in the last 5 years, become shorter, thinner or worn?
10. ☐ Are your teeth crowding or developing spaces?
11. ☐ Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?
12. ☐ Do you clench or grind your teeth?
13. ☐ Do you have any problems with sleeping or wake up with an awareness of your teeth?
14. ☐ Do you wear or have you ever worn a Night Guard (bite appliance)?

Tooth Structure

15. ☐ Have you had any cavities within the past 3 years?
16. ☐ Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
17. ☐ Do you feel or notice any holes (e.g. pitting, craters) on the biting surface of your teeth?
18. ☐ Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
19. ☐ Do you have grooves or notches on your teeth near the gum line?
20. ☐ Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
21. ☐ Do you get food caught between any teeth?

Gum and Bone

22. ☐ Do your gums bleed when brushing or flossing?
23. ☐ Have you ever been treated for gum disease or been told you have lost bone around your teeth?
24. ☐ Have you ever noticed an unpleasant taste or odour in your mouth?
25. ☐ Have you ever experienced gum recession?
26. ☐ Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
27. ☐ Have you experienced a burning sensation in your mouth?

Oral Self Care

28. ☐ Do you brush your teeth at least 2 times per day?
29. ☐ Do you floss your teeth daily?
30. ☐ Do you use mouth wash daily?
31. ☐ Do you use any other aids to clean your teeth and gums on a daily basis?

I, the undersigned, understand that the information contained in my dental history is important to my dental treatment. I certify that all the information is correct and that I have not knowingly omitted any information. I give consent to 2000 Yonge Dental to perform diagnostic procedures as may be necessary to provide necessary treatment. I assume all responsibility for fees associated with my dental treatment and/or diagnostic procedures.

Signature of patient, parent or guardian _____ Date DAY MO YEAR