Previous Dentist	DENTAL HISTORY				
PERSONAL HISTORY 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [Referred by How would you rate the condition of your mouth? Excellent Good I 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			Poor	
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [YES	NO	
2. Have you ever had on unifororable dental experience? 3. Have you ever had complications from past dental treatment? 4. Have you ever had oronible getting numb or had any reactions to local anesthetic? 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? GUM AND BONE 7. Do your gums bleed or are they painful when brushing or flossing? 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? 9. Have you ever neotred an unpleasant taste or odor in your mouth? 10. Is there anyone with a history of periodontal disease in your family? 11. Have you ever experienced gum recession? 12. Have you ever experienced gum recession? 13. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? 14. Have you had any cavities within the past 3 years? 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? 16. Do you feel or notice any holes (i.e. pitting, cartes) on the biting surface of your teeth? 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? 18. Do you have grooves or notches on your teeth near the gum line? 19. Have you ever broken teeth, ohipped teeth, or had a toothasche or cracked filling? 20. Do you frequently get food caught between any teeth? 21. Do you frequently get food caught between any teeth? 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? 23. Do you seld like your lower jaw is being pushed back when you try to bite your back teeth together? 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? 25. Are your teeth becoming more crooked, crowded, or overlapped? 26. Are your teeth becoming more crooked, crowded, or overlapped? 27. Oo you de	PI	ERSONAL HISTORY			
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