PINNACLE
DENTAL ASSOCIATES

Dental History

Date_____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist_____ How long have you been a patient? _____ Months/Years
Approximate date of most recent dental exam_____/____/____ Approximate date of most recent X-Rays _____/_____/_____
Approximate 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:

Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐ Yes ☐ No
Is there anything about the appearance of your teeth that you would like to change?	☐ Yes ☐ No
Do you/would you have any problems chewing gum?	☐ Yes ☐ No
Do you/would you have any problems chewing bagels or other hard foods?	☐ Yes ☐ No
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐ Yes ☐ No
Are your teeth crowding or developing spaces?	☐ Yes ☐ No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐ Yes ☐ No
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐ Yes ☐ No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐ Yes ☐ No
Do you have tension headaches or sore teeth?	☐ Yes ☐ No
Do you wear or have you ever worn a bite appliance?	☐ Yes ☐ No
Have you ever had trouble getting numb or reactions to local anesthetic?	☐ Yes ☐ No
Are you cavity prone?	☐ Yes ☐ No

Please rate, in order of value, what is most important to you in your dental care:

(The most important will be #1.)

____ Preventive care

____ Only what is necessary at the time: Cost is important

____ Comprehensive, quality care

____ Other _____

Please rate, as above, what is most important to you in your relationship with a dentist:

____ Show me what he/she is doing or planning to do so I can clearly see what is happening.

____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.

____ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have regarding dental treatment.

(10 being the most fearful, 1 being the least amount of fear.)

1 2 3 4 5 6 7 8 9 10

Patient's signature_____ Date_____

Doctor's signature_____ Date_____