DENTAL HISTORY

This is so we stay under local anesthesia toxicity.

Height:

Weight:

Patient Dental Issues:

- ☐ Difficulty swallowing
- ☐ Dry Mouth
- ☐ Clenching
- ☐ Grinding
- ☐ Facial Muscle Soreness
- ☐ Teeth Soreness
- ☐ Chew on Both Sides
- ☐ Chew only on One Side
- ☐ Other:

Patient Habits/Experiences:

- ☐ Coffee
- ☐ Soda
- ☐ Juice
- ☐ Energy drinks
- ☐ Iced tea no sugar
- ☐ Iced tea with sweetener
- ☐ Gatorade
- ☐ Chews on ice
- ☐ Sucks on lemons, or other citrus
- ☐ Sucks on hard candies or sugar cough drops
- ☐ Heartburn around major meals
- ☐ Regurgitation during the course of the day
- ☐ Other:

Patient Oral Hygiene Habits:

- ☐ Consistently
- ☐ Inconsistently
- ☐ Rarely
- ☐ Brushes
- ☐ Uses Power toothbrush
- ☐ Uses Manual toothbrush
- ☐ Flosses
- ☐ Uses flossers
- ☐ Uses Mouthrinse
- ☐ Uses Waterpik
- ☐ Uses Interproximal Brushes
- ☐ Uses Interproximal picks
- ☐ Uses Toothpicks
- ☐ Wears Retainer
- ☐ Wears Night Guard
- ☐ Wears Splint
- ☐ Other

Chief Complaint:

Other Dentist seen:

Last Xrays:

Last Dental Cleaning:

- ☐ Regularly
- ☐ Inconsistently
- ☐ Annually
- ☐ Every 3 months
- ☐ Every 4 months
- ☐ Every 6 months
- ☐ Alternates with Periodontist
- ☐ Never had a professional cleaning
- ☐ Wears dentures
- ☐ Other:

Prior Dental Work? Yes or No

- ☐ Whitening
- ☐ Braces
- ☐ Retainer
- ☐ Cleaning
- ☐ Fillings
- ☐ Root Canals
- ☐ Veneers
- ☐ Crowns
- ☐ Bridges
- ☐ Extractions
- ☐ Implants
- ☐ Dentures
- ☐ Partials
- ☐ Gum Surgery
- ☐ Deep Cleaning
- ☐ Splint
- ☐ Night Guard
- ☐ Other:

Top dental priorities according to patient:

- ☐ To keep as many teeth as possible and have a nice smile.
- ☐ Address pain and issues
- ☐ Other:

Patient would like to change their teeth or smile:

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Other:

DENTAL HISTORY

Expected outcomes according to the patient:

- ☐ To get treatment options
- ☐ Costs
- ☐ Other:

Other Patient Concerns:

PROSTHETIC DEVICE(S): Yes or No

- ☐ Implant Supported
- ☐ Tooth Supported
- ☐ Interim Removable Ptosthesis
- ☐ Acrylic
- ☐ Metal Framework
- ☐ Maxillary Removable Partial
- ☐ Mandibular RemovablePartial
- ☐ Maxillary Removable Complete Denture
- ☐ Mandibular Removable Complete Denture
- ☐ Maxillary Fixed Complete Denture
- ☐ Mandibular Fixed Complete Denture
- ☐ Other:

Worn for how long?

Existing/Current Set Made when?

What do you do to clean your Prosthesis?

- ☐ Doesn't take them off
- ☐ Overnight Denture tablets
- ☐ Soap and water
- ☐ Toothbrush
- ☐ Toothpaste
- ☐ Rinses them
- ☐ Other

Do you take your Prosthesis out at night?

- ☐ Yes
- ☐ No
- ☐ Daily
- ☐ Weekly
- ☐ Monthly