Dental Acquaintance and History Form

Because no two patients are the same, we would like to prepare for your first visit by getting to know you. Please take a few minutes to fill out this form so we may understand your previous dental experiences, your current concerns, and any goals you may have for your smile so we can personalize your care. Thank you!

Patient Name: ______________________________________ **Date:** __________________

What is your immediate dental concern? ____

____

Are you currently experiencing any dental pain? ○ Yes ○ No

If yes, please describe: ____

____

Is there anything we can do to make your visits more comfortable? _____________________________________

____

Past Dental History:

When was your last dental visit? ____

How many times a year do you typically have your teeth cleaned? ________________

Have you had any unfavorable experiences with a dentist? ○ Yes ○ No

If yes, please explain: ____

____

Do you suffer from anxiety during dental procedures?	○ Yes	○ No	
Do you have a sensitive gag reflex?	○ Yes	○ No	
Have been told you have periodontal disease?	○ Yes	○ No	
Do you have any dental implants?	○ Yes	○ No	How old are they? ______
Do you have existing crowns and bridges?	○ Yes	○ No	How old are they? ______
Do you wear partial dentures?	○ Yes	○ No	How old are they? ______
Have you ever worn braces?	○ Yes	○ No	
Do you have any holes or broken fillings?	○ Yes	○ No	

GLASTONBURY DENTAL ASSOCIATES

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Are you experiencing any of the following?

○ Sensitivity to cold liquids?
○ Difficulty swallowing?
○ Recent changes in your bite?
○ Loose or separating teeth?
○ Bleeding gums?
○ Sores, lumps or irritations anywhere in your mouth?
○ Tenderness on your gum tissue?
○ Bad taste in your mouth?
○ Cold sores or mouth ulcers
○ Numbness or tingling in your mouth?

Oral Hygiene Habits:
Please help us to understand your daily oral hygiene care. Do you currently use any of the following?

○Manual tooth brush ○Electric toothbrush ○Floss
○Floss threader ○Proxibrush ○Waterpik
○Rubber Tip ○Stimudents ○Fluoride Gel
○Mouthwash ○Tongue Scraper ○Prescription Toothpaste

How often do you brush your teeth?

Cavity Risk:
Do you have a well? ○ Yes ○ No
Has it been tested for Fluoride? ○ Yes ○ No
Do you chew gum? ○ Yes ○ No
What kind? ____________________
Do you have Acid Reflux? ○ Yes ○ No
Do you wake up with a bad taste in your mouth? ○ Yes ○ No

Do you regularly (1x or more per day) eat or drink any of the following?
○Coffee ○Soda ○Sports drinks (Gatorade, Poweraid) ○ Breath Mints
○Tea ○Juice ○Energy Drinks (Red Bull, Monster) ○Candy
○ Vinegar ○Citrus Fruit

TMJ Evaluation:

Are you currently under a lot of stress?	○ Yes	○ No
Do you get frequent headaches?	○ Yes	○ No
Do you have difficulty opening your mouth?	○ Yes	○ No
Do your jaws feel tired after eating?	○ Yes	○ No
After you wake up in the morning?	○ Yes	○ No
Do you ever hear popping or clicking sounds when you chew?	○ Yes	○ No
Do you ever have pain in your head, neck, shoulders and/or back?	○ Yes	○ No
Have you ever had a night guard made for you?	○ Yes	○ No
Have you been told you grind your teeth?	○ Yes	○ No

Cosmetic Concerns:
How do you feel about the color of your teeth? ____

____

Do you wish your teeth were straighter or a better shape? ____

____

On a Scale of 1-10, how would you rate your smile? ______ What do you wish it was? ______