JOHN RAVERA, DDS
GENERAL & COSMETIC DENTISTRY

DENTAL HISTORY

PATIENT NAME:
NAME AND CITY OF PREVIOUS DENTIST:
DATE OF LAST DENTAL VISIT AND WHAT TREATMENTS WERE RENDERED:
INITIAL CONCERN FOR TODAY'S VISIT:

DO YOU HAVE ANY DENTAL PROBLEMS NOW..... ☐ YES ☐ NO
DO YOU HAVE ANY TEETH THAT ARE SENSITIVE TO HOT – COLD – SWEETS..... ☐ YES ☐ NO

HAVE YOU EVER HAD:

ORTHODONTIC TREATMENT..... ☐ YES ☐ NO
ORAL SURGERY..... ☐ YES ☐ NO
PERIDONTAL TREATMENT..... ☐ YES ☐ NO
YOUR TEETH OR BITE ADJUSTED..... ☐ YES ☐ NO
A BITE PLATE OR OTHER APPLIANCE..... ☐ YES ☐ NO

HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH..... ☐ YES ☐ NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH..... ☐ YES ☐ NO
DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS..... ☐ YES ☐ NO
DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH..... ☐ YES ☐ NO
HAVE YOUR PARENTS EXPERIENCED GUM DISEASE..... ☐ YES ☐ NO

HAVE YOU EXPERIENCED:

CLICKING OF THE JAW..... ☐ YES ☐ NO
PAIN (JOINT, EAR, SIDE OF FACE)..... ☐ YES ☐ NO
DIFFICULTY IN OPENING OR CLOSING..... ☐ YES ☐ NO
DIFFICULTY IN CHEWING..... ☐ YES ☐ NO

DO YOU:

CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP..... ☐ YES ☐ NO
BITE YOUR LIPS OR CHEEKS REGULARLY..... ☐ YES ☐ NO
HOLD FOREIGN OBJECTS WITH YOUR TEETH (SUCH AS PENCILS, PIPE, NAILS, FINGERNAILS)..... ☐ YES ☐ NO
MOUTH BREATH WHILE AWAKE OR ASLEEP..... ☐ YES ☐ NO

DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT..... ☐ YES ☐ NO
HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE..... ☐ YES ☐ NO
DO YOU EXPECT TO EVENTUALLY LOSE YOUR TEETH..... ☐ YES ☐ NO
DO YOU LIKE THE APPEARANCE OF YOUR TEETH OR SMILE..... ☐ YES ☐ NO
DO YOU LIKE THE SHAPE AND COLOR OF YOUR TEETH..... ☐ YES ☐ NO
DO YOU HAVE SPACES BETWEEN YOUR TEETH OR CROWDED TEETH THAT BOTHERS YOU..... ☐ YES ☐ NO
DO YOU FEEL COMFORTABLE IN YOUR BITE, OR HOW YOUR TEETH COME TOGETHER..... ☐ YES ☐ NO
DO YOU HAVE ANY OLD FILLINGS OR DENTAL WORK THAT YOU DON'T LIKE LOOKING AT..... ☐ YES ☐ NO

IF YOU COULD CHANGE ANYTHING ABOUT YOUR TEETH OR SMILE, WHAT WOULD IT BE:_____

_____

_____