Charles Harding, DMD
Dental History

Referred by: _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐ Fair ☐ Poor
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): _____/_____/_____ Most recent 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:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth?	☐	☐
9. Are you self conscious about your teeth?	☐	☐
10. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
11. Do you/would you have any problems chewing gum?	☐	☐
12. Do you/would you have any problems chewing bagels or other hard goods?	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	☐	☐
14. Are your teeth crowding or developing spaces?	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
18. Do you have tension headaches or sore teeth?	☐	☐
19. Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years?	☐	☐
21. Do you have a dry mouth?	☐	☐
22. Are any teeth sensitive to hot, cold, biting, or sweets?	☐	☐
23. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth?	☐	☐
24. Do you avoid brushing any part of your mouth?	☐	☐
GUM AND BONE		
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
26. Have you ever experienced gum recession?	☐	☐
27. Is there anyone with a history of periodontal disease in your family?	☐	☐
28. Do your gums bleed when brushing, flossing, or eating?	☐	☐
29. Are your teeth becoming loose?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Have you experienced a burning sensation in your mouth?	☐	☐

In our office we use x-rays, video and digital images (computer x-ray and photo images) for diagnosis, documentation, reference, teaching and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration to potential and existing patients in our office or in other offices either in print media, on video or television or on digital media such as compact disc and the Internet. In some instances, you may be recognizable in some of these images.
By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization and release (or lack thereof) to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients. This authorization will remain in effect until cancelled. Any future cancellation will not affect the usability of images that have already been released. Please initial your choice:

☐ Any images can be used ☐ Images can be used, providing I am <u>not</u> recognizable ☐ I prefer <u>not</u> to have any images used.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____