Hedgecock Dental, PLLC

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Dental History

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

What is the name and phone number of your previous dentist?

_____

_____

What is the date of your most recent dental exam? _____

What is the date of your most recent cleaning? _____

What is the date of your most recent x-rays? _____

What is the date of your most recent treatment (other than a cleaning)? _____

What is your IMMEDIATE concern?

_____

_____

Personal History

Are you fearful fo dental treatment? ◯ Yes ◯ No

Have you had an unfavorable dental experience? ◯ Yes ◯ No

Have you ever had complications from past dental treatment? ◯ Yes ◯ No

Have you ever had trouble getting numb or had any reactions to local anesthetic? ◯ Yes ◯ No

Did you ever have braces, orthodontic treatment or had your bite adjusted? ◯ Yes ◯ No

Have you had any teeth removed? ◯ Yes ◯ No

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ◯ Yes ◯ No

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ◯ Yes ◯ No

Have you ever noticed an unpleasant taste or odor in your mouth? ◯ Yes ◯ No

Is there anyone with history of periodontal disease in your family? ◯ Yes ◯ No

Have you ever experienced gum recession? ◯ Yes ◯ No

Have you ever had any teeth become loose on their own(without injury), or do you have difficulty eating an apple? ◯ Yes ◯ No

Have you experienced a burning sensation in your mouth? ◯ Yes ◯ No

Tooth Structure

Have you had any cavities within the past 3 years? ◯ Yes ◯ No

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ◯ Yes ◯ No

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ◯ Yes ◯ No

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ◯ Yes ◯ No

Do you have grooves or notches on your teeth near the gum line? ◯ Yes ◯ No

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ◯ Yes ◯ No

Do you frequently get food caught between any teeth? ◯ Yes ◯ No

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ◯ Yes ◯ No

Do you feel like your lower jaw is being pushed back when you bite your teeth together? ◯ Yes ◯ No

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ◯ Yes ◯ No

Have your teeth changed in the last 5 years, become shorter, thinner or worn? ◯ Yes ◯ No

Are your teeth crowing or developing spaces? ◯ Yes ◯ No

Do you have more than one bite and squeeze to make your teeth fit together? ◯ Yes ◯ No

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ◯ Yes ◯ No

Do you clench your teeth in the daytime or make them sore? ◯ Yes ◯ No

Do you have any problems with sleep or wake up with an awareness of your teeth? ◯ Yes ◯ No

Do you wear or have you ever worn a bite appliance? ◯ Yes ◯ No

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ◯ Yes ◯ No

Have you ever whitened (bleached) your teeth? ◯ Yes ◯ No

Have you felt uncomfortable or self conscious about the appearance of your teeth? ◯ Yes ◯ No

Have you been disappointed with the appearance of previous dental work? ◯ Yes ◯ No

If there is anything you would like to elaborate on or any other dental condition you would like to add please use the space provided below:

☐ **By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other dental conditions that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**