Advanced Cosmetic and Implant Dentistry of Maryland

DENTAL HISTORY

Name: _____ Preferred Name (if applicable):_____

Previous Dentist: _____ How Long: _____

Approximate date of most recent dental visit: _____

Any immediate dental concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**	**Unknown**
1. sore or painful teeth	____	____	_____
2. unfavorable dental experiences at a dental office	____	_____	_____
3. dental fears	_____	_____	_____
4. problems with effectiveness or bad reactions to dental numbing medicine	_____	_____	_____
5. orthodontic treatment (braces) when: _____	____	_____	_____
6. periodontal/gum treatment (or "deep" cleaning) when:	_____	_____	_____
7. bleeding gums	_____	_____	_____
8. Been told you have gum disease or bone loss around your teeth	_____	_____	_____
9. part of your mouth is sensitive to temperatures	_____	_____	_____
10. would like laughing gas at your appointments	_____	_____	_____
11. get food caught between certain teeth consistently	_____	_____	_____
12. an unpleasant taste or odor in your mouth	_____	_____	_____
13. dry mouth	_____	_____	_____
14. jaw problems- temporomandibular joint (TMJ or TMD)	_____	_____	_____
15. Significant gag reflex	_____	_____	_____
16. difficulty opening your mouth widely	_____	_____	_____
17. difficulty having chair leaned back	_____	_____	_____
18. clench or grind your teeth	_____	_____	_____
19. lost any adult teeth (besides wisdom teeth)	_____	_____	_____
20. have wisdom teeth present	_____	_____	_____
21. Have had several cavities in your life or a cavity in the past 3 years	____	____	____

Concerning esthetic dentistry:

Yes, we do esthetic work and it is high quality and life changing. No, we don't push this. Everyone is different. Some people want to know how to improve the appearance of their teeth. Some couldn't care less. Both views are ok. We want to be considerate of your views in this manner.

Do you want to know about in office bleaching ($250) or other esthetic options (braces, veneers, etc)? Yes ____ No_____

On a scale of 1-10 please tell us how much detail you want to know concerning your dental work: _____
(1 = I don't care. Just do what you need to do.
10 = Please tell me every detail along the way.)

Patient/Guardian Signature: _____

If there is something you want us to know about you/your dental care please circle this area and write on the back of the form or below ⟶