



SOUTHPORT FAMILY DENTAL

10 John Street
Southport, CT 06890
Phone: 203-255-5142

DENTAL HISTORY: Please Circle

Do you have any specific dental problems or areas of concern? _____	Yes	No
Do you have dental examinations and preventive maintenance on a routine basis? Last visit _____	Yes	No
Do you think you have active decay or gum disease? _____	Yes	No
Do you brush and floss on a regular basis? Discuss _____	Yes	No
Have you been given good home care instructions? _____	Yes	No
Are your teeth sensitive to: Hot, Cold, Sweets, Pressure _____	Yes	No
Do you have any untreated dental problems that you are aware of? Discuss _____	Yes	No

Have You Ever Had?

Orthodontic treatment Oral surgery Periodontal treatment Your bite adjusted Worn and bite plate/ night guard
Other: _____

Have You Noticed?

Loosening of your teeth Food catching between teeth Pain/Swelling of gums Sores or growths in your mouth
Bleeding gums when brushing and flossing Bad Breath -What have you done to treat it? _____
Do you smoke or chew tobacco? Other: _____

Have you heard of Periodontal Disease? (Gum Disease) _____ Yes No

Do you want to keep your remaining teeth? How long? _____ Yes No

Have You Experienced?

Clicking of the jaw Pain (joint, ears, side of face) Difficulty in opening/closing your mouth
Difficulty in chewing, favor one side Other: _____

Are you pleased with the quality of your smile? _____ Yes No

What do you like about your smile? _____

If you could change one thing about your smile, what would it be? (check all that apply)

Whiten teeth Straight Teeth Lengthen Teeth Shorten Teeth
Replace Missing Teeth Fix Spaces Between Teeth Replace Old Silver Fillings Make Smile Less
"Gummy"
Everything! Need a Smile Makeover
Other (Please Explain) _____

What is most important to you in a dentist? _____

What do you expect from our office? _____

What did you like best about previous dental office? Dentist/Staff _____

What did you like least? _____

Have your past experiences in a dental office always been positive? _____ Yes No

Do you want the very best dentistry we can provide for you – or want us to patch it and get by? _____ Yes No

If we find out something that needs to be done in your mouth, do you want all the Details Overview

On a scale of 1 – 10, where would you rate your fear of dentistry? _____

What is most important to you in the dental treatment you receive? _____

What do you envision your mouth being like in 10 to 15 years? _____

Should we see something that needs to be done that your insurance doesn't cover, what would you like to do about it?

Date of last full mouth x-rays (18 small films or panoramic): _____ Yes No

Name of previous dentist (optional): _____ Yes No

Do you have a removable partial or completed denture (If not, please go to the next section) Yes No

Please answer the following if you do:

Have you had difficulty chewing foods? Yes No

Has your sense of taste declined? Yes No

Does food catch in your dentures? Yes No

Have you had pain in your mouth? Yes No

Have you had headaches that you believe are related to your dentures? Yes No

Have you found it uncomfortable to eat certain foods? Yes No

Are you frequently self conscious because of your dentures? Yes No

Do your teeth seem to click when you speak? Yes No

Are you smiling less now that you have false teeth? Yes No

Do you snore more than you used to? Yes No

Have you been upset or irritable because of your dental condition? Yes No

Have you felt that life in general is less satisfying because of your dental condition? Yes No

Would you be interested in finding out if your dentures can be stabilized? Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____

Significant Findings _____