Millersville Family Dentistry

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Dental History

What would you like to accomplish today? _____
What prompted you to seek dental care at this time? _____
Have you been asked to take antibiotic before dental treatment? ☐ Yes ☐ No

Please check if you have ever had problems with any of the following:

☐ Sensitivity to cold	☐ Jaw/ear pain	☐ Bleeding Gums	☐ Food sticks between teeth
☐ Sensitivity to hot	☐ Grinding/clenching teeth	☐ Periodontal treatment	☐ Mouth sores/growth
☐ Sensitivity when biting	☐ Clicking or popping jaw	☐ Loose teeth/broken fillings	☐ Bad breath/taste
☐ Sensitivity to sweets	☐ Worn/chipped teeth	☐ Dark teeth	☐ Hard to floss

Home Care Evaluation

How often do you brush? _____ Toothbrush: ☐ Electric ☐ Regular ☐ Soft ☐ Medium ☐ Hard
How often do you brush? _____ Any other home care devices that you use?_____
Is it difficult for you to brush or floss any areas of your mouth? ☐ Yes ☐ No
If yes, please describe: _____
Do your gums bleed when brushing or flossing? ☐ Yes ☐ No
Do you have dry mouth? ☐ Yes ☐ No
Do you want to learn to control dental disease and keep your teeth? ☐ Yes ☐ No
Have you ever been instructed in the prevention of decay? ☐ Yes ☐ No
Have you been instructed in caring for the health of your gums? ☐ Yes ☐ No
Do you feel like keeping your teeth healthy has been a losing battle? ☐ Yes ☐ No
If yes, why?_____
Do you have any concerns about getting your mouth in excellent health? ☐ Yes ☐ No
If yes, what concerns you?_____
Do you snack between meals on sweets, gum, or soda pop? ☐ Yes ☐ No
Do you chew on both sides of your mouth? ☐ Yes ☐ No

Smile Evaluation

How do you feel about the appearance of your teeth?_____
Do you like the way your smile looks? ☐ Yes ☐ No
If no, what dissatisfies you?_____
Do you sometimes hesitate to smile? ☐ Yes ☐ No
Are your teeth white enough? ☐ Yes ☐ No
Are there old fillings or dental work that looks bad to you? ☐ Yes ☐ No
Do you like the shape of your teeth? ☐ Yes ☐ No
Are your teeth straight enough? ☐ Yes ☐ No
Do you have spaces between your teeth that you don't like? ☐ Yes ☐ No
Has cost prevented you from enhancing your smile in the past? ☐ Yes ☐ No

Other History

Are you anxious about receiving dental treatment? ☐ Yes ☐ No
If yes, what do you dislike?_____
Has fear of discomfort kept you from regular dental visits in the past? ☐ Yes ☐ No
What else would you like us to know about you past dental experiences?_____
Have you ever had a reaction to a dental product or procedure? ☐ Yes ☐ No
If yes, please describe:_____

Previous Dentist: _____
Name City, State Phone

Date of Last Visit: _____ Date of Last X-rays: _____
Month/Year Month/Year