FAY DENTISTRY
BIOMIMETIC | AESTHETICS | OCCLUSION

16 Old Riverhead Road
Westhampton, NY 11978
631.288.9000

DENTAL HISTORY

Patient Name: LAST _____ FIRST _____ Birthdate: _____

Name of pervious dentist: _____

Date of most recent dental exam: _____ Date of most recent dental radiographs: _____

Date of most recent treatment (other than a cleaning): _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your immediate concern?

_____

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you had complications from a past dental experience?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
Do you wear a retainer?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease, had scaling or root planning or have you ever had or been told that you have gum loss, gum disease or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury) or feel them move when chewing?	☐	☐
13. Have you experienced a burning or painful sensation or metallic taste in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities in the past three years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between your teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking) or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars or other hard, dry foods?	☐	☐
24. In the past five years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime/ nighttime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient/Guardian Signature

Doctor Signature

Relationship to Patient