Justin Pagan, DDS, MSD
Orthodontic Specialist

DENTAL HISTORY

Patient Name:

General Dentist:

Date of Last Visit:

General Dentist Address:

General Dentist Phone no:

Personal History	If yes, describe	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 ever had complications from past dental treatment?		☐	☐
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?		☐	☐
6 Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		☐	☐
7 Do you have difficulty breathing through your nose?		☐	☐
8 Any type of tongue or thumb habit?		☐	☐

Bite And Jaw	If yes, describe	Yes	No
9 Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		☐	☐
10 Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?		☐	☐
11 Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		☐	☐
12 In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		☐	☐
13 Are your teeth becoming more crooked, crowded, or overlapped?		☐	☐
14 Are your teeth developing spaces or becoming more loose?		☐	☐
15 Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?		☐	☐
16 Do you place your tongue between your teeth or close your teeth against your tongue?		☐	☐
17 Do you clench or grind your teeth together in the daytime or make them sore?		☐	☐
18 Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		☐	☐
19 Do you wear or have you ever worn a bite appliance?		☐	☐

Smile Characteristics	If yes, describe	Yes	No
20 Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?		☐	☐
21 Have you felt uncomfortable or self conscious about the appearance of your teeth?		☐	☐
22 Have you been disappointed with the appearance of previous dental work?		☐	☐

Gums	If yes, describe	Yes	No
23 Do your gums bleed or are they painful when brushing or flossing?		☐	☐
24 Have you ever been treated for gum disease or been told you have lost bone around your teeth?		☐	☐

Patient / Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____