Hunsaker Dental

DENTAL HISTORY

Patient Name: _____ Date: _____ Birthdate: _____

Please answer the following questions in order to help us better serve you.

What is the reason for your visit today? _____

Are you experiencing any dental pain or discomfort? ☐Yes ☐No If yes: _____

Are any of your teeth sensitive to: ☐Hot ☐Cold ☐Sweets ☐Pressure

Have you noticed any mouth odors or bad tastes? ☐Yes ☐No

Does food get caught in your teeth? ☐Yes ☐No

Do you have a problem with dry mouth? ☐Yes ☐No

Do you clench or grind your teeth? ☐Yes ☐No

Do you have problems with your jaw joint?

☐Pain ☐Sounds ☐Locking ☐Popping ☐Limited Opening

Do you have any missing teeth? ☐Yes ☐No

If yes, which replacement options appeal most to you?

☐Dentures ☐Partials ☐Implants ☐Bridges ☐Other

Is there anything about the appearance of your teeth that you would like to change?

☐Spacing ☐Crowding ☐Rotated Teeth ☐Overbite ☐Shape of teeth

☐Color of teeth ☐Other ☐I'm happy with my teeth

Do you, or have you ever been told that you snore? ☐Yes ☐No

Have you ever been diagnosed with sleep apnea ☐Yes ☐No

Do you use, or have you ever used a CPAP Machine? ☐Yes ☐No

If yes, do you like your CPAP? ☐Yes ☐No

How often do you brush your teeth?

☐Twice per day or more ☐Once per day ☐Once every 2-3 days ☐Once per week

☐Once per month ☐Rarely ☐Never

How often do you floss?

☐Once or twice per day ☐A few times a week ☐Once per week ☐Once or twice per Month

☐Rarely ☐Never

Do you use any oral care item? ☐Yes ☐No If yes:_____

Do you have trouble cleaning or caring for your teeth? ☐Yes ☐No If Yes: _____

Have you ever had trouble getting numb or had

any reactions to local anesthetic? ☐Yes ☐No If yes:_____

Do you feel nervous about dental treatment? ☐Yes ☐No If yes: _____

Do you have any other dental concerns or comments not listed? _____