Buffalo Prairie Dental

Quincy@buffaloprairiedental.com Keokuk@buffaloprairiedental.com www.buffaloprairiedental.com

2801 Broadway Quincy IL 62301 3327 Main St Keokuk IA 52632 126 N 30th St Quincy IL 62301 (217) 224-7645 / (319) 524-8811 / (217)228-3384

Dental History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

What is the name and phone number of your previous dentist?

What is the date of your most recent dental exam? _____

What is the date of your most recent cleaning? _____

What is the date of your most recent x-rays? _____

What is the date of your most recent treatment (other than a cleaning)? _____

What is your IMMEDIATE concern?

Personal History

Are you fearful of dental treatment? ◯ Yes ◯ No

Have you ever had trouble getting numb or had any reactions to local anesthetic? ◯ Yes ◯ No

Did you ever have braces, orthodontic treatment or had your bite adjusted? ◯ Yes ◯ No

Have you had any teeth removed? ◯ Yes ◯ No

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ◯ Yes ◯ No

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ◯ Yes ◯ No

Have you ever noticed an unpleasant taste or odor in your mouth? ◯ Yes ◯ No

Is there anyone with history of periodontal disease in your family? ◯ Yes ◯ No

Have you ever experienced gum recession? ◯ Yes ◯ No

Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? ◯ Yes ◯ No

Tooth Structure

Have you had any cavities within the past 3 years? ◯ Yes ◯ No

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ◯ Yes ◯ No

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ◯ Yes ◯ No

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ◯ Yes ◯ No

Do you have broken or chipped teeth? ◯ Yes ◯ No

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ◯ Yes ◯ No

Do you frequently get food caught between any teeth? ◯ Yes ◯ No

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ◯ Yes ◯ No

Do you have any difficulty chewing? ◯ Yes ◯ No

Are your teeth crowing or developing spaces? ◯ Yes ◯ No

Do you have more than one bite and squeeze to make your teeth fit together? ◯ Yes ◯ No

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ◯ Yes ◯ No

Do you clench your teeth in the daytime or make them sore? ◯ Yes ◯ No

Do you have any problems with sleep or wake up with an awareness of your teeth? ◯ Yes ◯ No

Do you wear or have you ever worn a bite appliance? ◯ Yes ◯ No

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ◯ Yes ◯ No

On a Scale of 1 -10 with 10 being the highest, how would you rate your smile? _____

What would you like it to be? _____

Would you like your teeth whitened? ◯ Yes ◯ No

Would you like to straighten your teeth? ◯ Yes ◯ No

If there is anything you would like to elaborate on or any other dental condition you would like to add please use the space provided below:

☐ **By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other dental conditions that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**