RDA ROESER DENTAL ASSOCIATES, P.C.

Patient Name:

Date: Date of Birth:

Dental History

Y N

☐ ☐ Are you in good dental health? If not, explain: _____

☐ ☐ Do you have any present dental complaints? If so, what? _____

☐ ☐ Have you ever had a problem following a dental procedure? If so, what? _____

☐ ☐ Have you ever been instructed in the prevention of tooth decay?

☐ ☐ Have you ever been instructed in caring for your teeth and gums?

☐ ☐ Do you have Fluoride in your drinking water?

☐ ☐ Do you use Fluoride toothpaste?

☐ ☐ Do you have a family history of decayed, missing or filled teeth? If yes, explain: _____

☐ ☐ Do you have a family history of congenitally missing permanent teeth? If yes, explain: _____

☐ ☐ Do you have a dry mouth or condition that impairs saliva?

Time lapse since last cavity? ☐ <12 months ☐ 12-24 months ☐ >24 months

Frequency of routine dental visits? ☐ Every 6 months ☐ Irregular ☐ None

When was your last dental visit? _____

Daily between meal exposures to sugars/cavity producing foods (includes on demand use of liquids other than water or use of sweetened medications)? ☐ >3 ☐ 1-2 ☐ Mealtime Only

Times per day teeth/gums are brushed? ☐ 2-3 ☐ 1 ☐ None

Times per day teeth/gums are flossed? ☐ >1 ☐ 1 ☐ None

Socioeconomic status: ☐ Low ☐ Mid-level ☐ High

On a scale of 1 to 10 how frightened are you of dental treatment (10 is very frightened)? _____

Do you have or have you ever had:

Y	N	Conditions
☐	☐	Tooth Decay
☐	☐	Gum Disease
☐	☐	Braces or Orthodontics
☐	☐	Root Canals
☐	☐	Tooth Extractions
☐	☐	Jaw Pain
☐	☐	Temporomandibular Disorder
☐	☐	Complete or Partial Dentures
☐	☐	Tooth Aches
☐	☐	Sensitive Teeth
☐	☐	Dental Implants
☐	☐	Bridges

Smile Evaluation

Y	N		
☐	☐	Do you like the appearance of your teeth; smile? If not, explain:	
☐	☐	Are your teeth all in alignment (straight)? If not, explain:	
☐	☐	Do you have spaces that you do not like? If yes, explain:	
☐	☐	Do you like the color of your teeth? If not, explain:	
☐	☐	Do you like the shape of your teeth? If not, explain:	
☐	☐	Are your teeth chipped, protruding, or hidden? If yes, explain:	
☐	☐	Are your teeth wearing on the biting surfaces? If yes, explain:	
☐	☐	Are there old fillings or dental work you do not like looking at? If yes, explain:	
☐	☐	Would you like to have whiter straighter teeth?	
☐	☐	If we could staighten your teeth without braces, would you be interested?	
☐	☐	What would you like to change the most in the appearance of your teeth?	
☐	☐	Are your teeth wearing on the biting surfaces? If yes, explain:	
		How would you like your teeth to look?	

Reviewed by: _____ Date: _____ **Patient Signature:** _____ **Date:** _____

If under 18, Parent or Guardian Required