ARTHUR dental group

Dental Health Information

Patient Name: _____

Dental History

Approximate date of your last dental visit? _____

Approximate date of your last professional dental cleaning? _____

Have you ever had an unfavorable dental experience? _____

Are you fearful of the dentist? *Yes* *No* Do you have difficulty getting numb? *Yes* *No*

Have you ever had an adverse reaction to dental anesthesia? *Yes* *No*

Have you ever had braces or orthodontic treatment? *Yes* *No* When? _____

Do you wear a retainer? *Yes* *No*

Do you or have you ever worn a dental appliance (nightguard, mouthguard, snoreguard, etc.)? *Yes* *No*

Are you missing any teeth? *Yes* *No* If so, are you interested in replacing them? *Yes* *No*

Are you unhappy with the appearance of your teeth? *Yes* *No*

Is it important that you keep your teeth for the rest of your life? *Yes* *No*

Please check any of the following concerns you have about your mouth, teeth, or gums:

☐ Bad breath ☐ Bad taste ☐ Missing teeth ☐ Broken teeth ☐ Toothache ☐ Broken fillings

☐ Old fillings ☐ Gingivitis ☐ Bad bite ☐ Bleeding gums ☐ Dark or stained teeth

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Tooth Structure, Bite, & Jaw Joint

Are your teeth sensitive to any of the following: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure/Biting

Do you have grooves or notches at the gumline? *Yes* *No*

Have you ever cracked, chipped, or broken any teeth? *Yes* *No*

Do you or have you been told that you clench and/or grind your teeth? *Yes* *No*

In the past five (5) years, have your teeth become shorter, thinner, or worn? *Yes* *No*

Do you have pain in your jaw joints when you open or close? *Yes* *No*

Do your jaw joints make noises when you open or close? *Yes* *No*

Do you experience frequent headaches? *Yes* *No*

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Gum & Bone

Do your gums bleed or are they painful when you brush or floss? *Yes* *No*

Have you ever been told that you have bone loss or periodontal disease? *Yes* *No*

Does anyone in your family have periodontal disease? *Yes* *No*

Are your teeth loose? *Yes* *No*

Do you tend to pack food between your teeth? *Yes* *No*

Airway & Sleep

Do you have a CPAP machine? *Yes* *No*

If so, do you use it? *Yes* *No*

Have you ever been told that you snore? *Yes* *No*

Do you wake up feeling fatigued? *Yes* *No*

Has anyone ever observed that you stop breathing in your sleep? *Yes* *No*

Epworth Sleepiness Scale

Please rate how likely you are to fall asleep during the following activities

0: would never doze;1: Slight chance of dozing; 2: Moderate chance of dozing; 3: High chance of dozing

0 1 2 3 Sitting and reading

0 1 2 3 Watching television

0 1 2 3 Sitting inactively in a public place

0 1 2 3 As a passenger in a car for an hour without a break

0 1 2 3 Lying down to rest in the afternoon

0 1 2 3 Sitting and talking with someone

0 1 2 3 Sitting quietly after lunch without alcohol

0 1 2 3 Driving a car stopped in traffic at a stop light

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Patient Name: _____

Patient Consent

Thank you for choosing our office for your dental care. We continually work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions. Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure including:

1. *Drug or chemical reaction: Dental materials and medications may trigger allergic or sensitivity reactions.*
2. *Long-term numbness (paresthesia): local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.*
3. *Muscle or joint tenderness: Holdings one's mouth open can result in tenderness or in a predisposed patient precipitate a TMJ disorder.*
4. *Sensitivity in teeth or gums, infection, or bleeding.*
5. *Swallowing or inhaling small objects.*

While we follow procedural guidelines which most often lead to clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page.

Signature: _____ Date: _____

Parent/Guardian Signature (if minor patient): _____ Date: _____