Skylands
DENTAL OF NEW JERSEY, LLC
117 Grand Avenue
Hackettstown, New Jersey 07840
(908) 850-0005

DENTAL HISTORY: Please Circle

Do you have any specific dental problems or areas of concern? _____ ☐ Yes ☐ No
Do you have dental examinations and preventive maintenance on a routine basis? Last visit _____ ☐ Yes ☐ No
Do you think you have active decay or gum disease? _____ ☐ Yes ☐ No
Do you brush and floss on a regular basis? Discuss_____ ☐ Yes ☐ No
Have you been given good home care instructions? _____ ☐ Yes ☐ No
Are your teeth sensitive to: Hot, Cold, Sweets, Pressure _____ ☐ Yes ☐ No
Do you have any untreated dental problems that you are aware of? Discuss _____ ☐ Yes ☐ No

Have You Ever Had?

☐ Orthodontic treatment ☐ Oral surgery ☐ Periodontal treatment ☐ Your bite adjusted ☐ Worn and bite plate/ night guard
☐ Other: _____

Have You Noticed?

☐ Loosening of your teeth ☐ Food catching between teeth ☐ Pain/Swelling of gums ☐ Sores or growths in your mouth
☐ Bleeding gums when brushing and flossing ☐ Bad Breath -What have you done to treat it? _____
☐ Do you smoke or chew tobacco? ☐ Other: _____

Have you heard of Periodontal Disease? (Gum Disease) _____ ☐ Yes ☐ No

Do you want to keep your remaining teeth? How long? _____ ☐ Yes ☐ No

Have You Experienced?

☐ Clicking of the jaw ☐ Pain (joint, ears, side of face) ☐ Difficulty in opening/closing your mouth
☐ Difficulty in chewing, favor one side ☐ Other: _____

Are you pleased with the quality of your smile? _____ ☐ Yes ☐ No
What do you like about your smile? _____

If you could change one thing about your smile, what would it be? (check all that apply)

☐ Whiten teeth ☐ Straight Teeth ☐ Lengthen Teeth ☐ Shorten Teeth
☐ Replace Missing Teeth ☐ Fix Spaces Between Teeth ☐ Replace Old Silver Fillings ☐ Make Smile Less "Gummy"
Everything! Need a Smile Makeover
Other (Please Explain) _____

What is most important to you in a dentist? _____

What do you expect from our office? _____

What did you like best about previous dental office? Dentist/Staff _____

What did you like least? _____

Have your past experiences in a dental office always been positive? _____ ☐ Yes ☐ No

Do you want the very best dentistry we can provide for you – or want us to patch it and get by? _____ ☐ Yes ☐ No

If we find out something that needs to be done in your mouth, do you want all the ☐ Details ☐ Overview

On a scale of 1 – 10, where would you rate your fear of dentistry? _____

What is most important to you in the dental treatment you receive? _____

What do you envision your mouth being like in 10 to 15 years? _____

Should we see something that needs to be done that your insurance doesn't cover, what would you like to do about it?

_____

Date of last full mouth x-rays (18 small films or panoramic):_____ ☐ Yes ☐ No

Name of previous dentist (optional):_____ ☐ Yes ☐ No

Do you have a removable partial or completed denture (If not, please go to the next section) ☐ Yes ☐ No

Please answer the following if you do:

Have you had difficulty chewing foods?	☐ Yes	☐ No
Has your sense of taste declined?	☐ Yes	☐ No
Does food catch in your dentures?	☐ Yes	☐ No
Have you had pain in your mouth?	☐ Yes	☐ No
Have you had headaches that you believe are related to your dentures?	☐ Yes	☐ No
Have you found it uncomfortable to eat certain foods?	☐ Yes	☐ No
Are you frequently self conscious because of your dentures?	☐ Yes	☐ No
Do your teeth seem to click when you speak?	☐ Yes	☐ No
Are you smiling less now that you have false teeth?	☐ Yes	☐ No
Do you snore more than you used to?	☐ Yes	☐ No
Have you been upset or irritable because of your dental condition?	☐ Yes	☐ No
Have you felt that life in general is less satisfying because of your dental condition?	☐ Yes	☐ No
Would you be interested in finding out if your dentures can be stabilized?	☐ Yes	☐ No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X_____Date_____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor_____ Date_____

Significant Findings _____

_____

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