Volki Felahy, DDS

www.sunsetoakdental.com
2161 Sunset Blvd.#300 • Rocklin, CA 95765 (916)435-5111

DENTAL HISTORY

Chart#: _____
FOR OFFICE USE ONLY

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

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

WHAT IS YOUR IMMEDIATE CONCERN?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? ◯ Yes ◯ No

2. Have you had an unfavorable dental experience? ◯ Yes ◯ No

3. Have you ever had complications from past dental treatment? ◯ Yes ◯ No

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

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

6. Have you had any teeth removed? ◯ Yes ◯ No

GUM AND BONE

7. Do your gums bleed or are they painful during brushing or flossing? ◯ Yes ◯ No

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

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

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

11. Have you ever experienced gum recession? ◯ Yes ◯ No

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

13. Have you experienced a burning sensation in your mouth? ◯ Yes ◯ No

TOOTH STRUCTURE

14. Have you had any cavities within the last three years? ◯ Yes ◯ No

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

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

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

18. Do you have grooves or notches on your teeth near the gumline? ◯ Yes ◯ No

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

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

BITE AND JAW JOINT

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

22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ◯ Yes ◯ No

23. Do you avoid or have trouble chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ◯ Yes ◯ No

24.Have your teeth changed in the last 5 years, become shorter, thinner, or worn? ◯ Yes ◯ No

25. Are your teeth crowding or developing spaces? ◯ Yes ◯ No

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

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

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

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

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

SMILE CHARACTERISTICS

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

32. Have you ever whitened (bleached) your teeth? ◯ Yes ◯ No

33. Have you felt uncomfortable or self conscious about the appearance of your teeth? ◯ Yes ◯ No

34. Have you been disappointed with the appearance of previous dental work? ◯ Yes ◯ No

---

Response Date: _____