Oliver Dental Care
Dr. Jordan Noftle DMD. BSc, BEd

DENTAL HISTORY

Phone: 250.498.2323 | Email: info@oliverdentalcare.com

PATIENT NAME First Name, Last Name **PREFERRED NAME** First Name, Last Name **AGE** Age

REFERRED BY First Name, Last Name **HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PREVIOUS DENTIST First Name, Last Name **HOW LONG HAVE YOU BEEN A PATIENT?** MM/YY Months / Years

DATE OF MOST RECENT EXAM YYYY / MM / DD **DATE OF MOST RECENT X-RAYS** YYYY / MM / DD

DATE OF MOST RECENT TREATMENT (OTHER THAN A CLEANING) YYYY / MM / DD

I ROUTINELY SEE MY DENTIST EVERY ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not Routinely

WHAT IS YOUR IMMEDIATE CONCERN? Please Specify

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [1-10]	☐ Y ☐ N	Please specify if required
2	Have you had an unfavorable dental experience?	☐ Y ☐ N	Please specify if required
3	Have you ever had complications from past dental treatment?	☐ Y ☐ N	Please specify if required
4	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐ Y ☐ N	Please specify if required
5	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐ Y ☐ N	Please specify if required
6	Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐ Y ☐ N	Please specify if required

GUM AND BONE

7	Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐ Y ☐ N	Please specify if required
8	Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐ Y ☐ N	Please specify if required
9	Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐ Y ☐ N	Please specify if required
10	Is there anyone with a history of periodontal disease in your family?	☐ Y ☐ N	Please specify if required
11	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐ Y ☐ N	Please specify if required
12	Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐ Y ☐ N	Please specify if required
13	Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐ Y ☐ N	Please specify if required

TOOTH STRUCTURE

14	Have you had any cavities within the past 3 years?	☐ Y ☐ N	Please specify if required
15	Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐ Y ☐ N	Please specify if required
16	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐ Y ☐ N	Please specify if required
17	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐ Y ☐ N	Please specify if required
18	Do you have grooves or notches on your teeth near the gum line?	☐ Y ☐ N	Please specify if required
19	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐ Y ☐ N	Please specify if required
20	Do you frequently get food caught between any teeth?	☐ Y ☐ N	Please specify if required

BITE AND JAW JOINT

21	Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐ Y ☐ N	Please specify if required
22	Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐ Y ☐ N	Please specify if required
23	Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐ Y ☐ N	Please specify if required
24	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐ Y ☐ N	Please specify if required
25	Are your teeth becoming more crooked, crowded, or overlapped?	☐ Y ☐ N	Please specify if required
26	Are your teeth developing spaces or becoming more loose?	☐ Y ☐ N	Please specify if required
27	Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐ Y ☐ N	Please specify if required
28	Do you place your tongue between your teeth or close your teeth against your tongue?	☐ Y ☐ N	Please specify if required
29	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ Y ☐ N	Please specify if required
30	Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐ Y ☐ N	Please specify if required
31	Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐ Y ☐ N	Please specify if required
32	Do you wear or have you ever worn a bite appliance?	☐ Y ☐ N	Please specify if required

SMILE CHARACTERISTICS

33	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐ Y ☐ N	Please specify if required
34	Have you ever bleached (whitened) your teeth?	☐ Y ☐ N	Please specify if required
35	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐ Y ☐ N	Please specify if required
36	Have you been disappointed with the appearance of previous dental work?	☐ Y ☐ N	Please specify if required

Patient's Signature First Name, Last Name Date YYYY/MM/DD

Dentist's Signature First Name, Last Name Date YYYY/MM/DD

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