Dr. Samantha Greer, DDS, PA

Patient Name: ____ Date: ________________________________

Dental Information
What is the reason for your visit today? ____________________ When was your last dental visit? ________________
When was your last dental cleaning? ______________________ How often do you brush your teeth? _____________
How often do you floss? ____________________ What texture toothbrush do you use? Soft □ Medium □ Hard □
Do you have sensitivity to: Hot □ Cold □ Biting □ Pressure □ Sweets □ Other □

Yes	No	Don't Know	
□	□	□	Have you ever heard any clicking or popping in your jaw joints-immediately in front of your ears?
□	□	□	Have you ever experienced headaches, near your temples, upon awakening in the morning?
□	□	□	Have you ever experienced chewing muscle soreness or tension upon awakening in the morning
□	□	□	Have you ever had jaw joint pain during chewing?
□	□	□	Has yawning or opening wide ever caused you pain?
□	□	□	Has your jaw ever been stuck or locked open, even if for a brief moment?
□	□	□	Have you ever felt that your teeth didn't meet in a comfortable position?
□	□	□	Has a dentist ever devoted one or more appointments to precision bite adjustment or "equilibration"?
□	□	□	Have you ever been struck on, or received injury to the head, neck or jaw?
□	□	□	Have you ever had any episodes of pain in the jaw joint?
□	□	□	Have you ever ground your teeth while sleeping?
□	□	□	Do you find yourself clenching your teeth during the day?
□	□	□	Do your jaw muscles tire while eating or talking?
□	□	□	Do you have arthritis?
□	□	□	Have you ever been treated in the past for TMJ problems?
□	□	□	Have you ever noticed difficulty or limitation in opening?
□	□	□	Have you ever noticed recent shifting, crowding, rotating or new spaces opening?
□	□	□	Have you ever noticed loose teeth?

Do You Or Have Your Ever Had:

Yes	No	Don't Know	
□	□	□	Orthodontics (braces)
□	□	□	Periodontal (gum) treatment
□	□	□	Complications from dental treatment
□	□	□	Loosening of teeth
□	□	□	Blisters or sores on lips or in mouth
□	□	□	Food collecting between your teeth
□	□	□	Oral surgery

Yes	No	Don't Know	
□	□	□	Worn a nightguard or other appliance
□	□	□	Bleeding or sore gums
□	□	□	Swelling or lumps in mouth
□	□	□	Trauma to your jaw, head or neck
□	□	□	Unpleasant taste
□	□	□	Problems with bad breath (halitosis)

Esthetics:

Yes	No	Don't Know	
□	□	□	Are you pleased with the appearance of your teeth?
□	□	□	Do you like the shape of your teeth?
□	□	□	Do you like the color of your teeth?
□	□	□	Are you interested in learning how to enhance your smile?
□	□	□	Is there anything you would like to change about the appearance of your teeth? ________________

Is there anything else in your past dental history you feel I should know? ____________________________________
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