PAGAN
ORTHODONTICS

Justin Pagan, DDS, MSD
ORTHODONTIC SPECIALIST

DENTAL HISTORY

Date of last visit _____

Name _____

General Dentist _____ General Dentist Phone _____

General Dentist Address _____

Personal History

_____If yes, describe

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ 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 trouble getting numb or had any reactions to local anesthetic? _____ ☐ Yes ☐ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ ☐ Yes ☐ No
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ ☐ Yes ☐ No
7. Do you have difficulty breathing through your nose? _____ ☐ Yes ☐ No
8. Any type of tongue or thumb habit? _____ ☐ Yes ☐ No

Bite And Jaw

_____If yes, describe

9. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ Yes ☐ No
10. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____ ☐ Yes ☐ No
11. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ___ ☐ Yes ☐ No
12. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ ☐ Yes ☐ No
13. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ Yes ☐ No
14. Are your teeth developing spaces or becoming more loose? _____ ☐ Yes ☐ No
15. Do you have trouble finding your bite, or need to squeeze, tap your teeth together or shift your jaw to make your teeth fit together? _____ ☐ Yes ☐ No
16. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ Yes ☐ No
17. Do you clench or grind your teeth together in the daytime or make them sore? _____ ☐ Yes ☐ No
18. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ ☐ Yes ☐ No
19. Do you wear or have you ever worn a bite appliance? _____ ☐ Yes ☐ No

Smile Characteristics

_____If yes, describe

20. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____ ☐ Yes ☐ No
21. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ Yes ☐ No
22. Have you been disappointed with the appearance of previous dental work? _____ ☐ Yes ☐ No

Gums

_____If yes, describe

23. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ Yes ☐ No
24. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ Yes ☐ No

Patient / Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____