WILLIAM LINGER DDS, MAGD
Caring & Personal Dentistry

Patient name: _____ Date: _____

What is your Immediate concern?_____

1. Are you fearful of the dental treatment? Y/N
2. Have you had an unfavorable dental experience? Y/N
3. Have you ever had complications from past dental treatment? Y/N
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? Y/N
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? Y/N
6. Have you had any teeth removed? Y/N

Smile Characteristics

7. Is there anything about the appearance of your teeth that you would like to change? Y/N
8. Have you ever whitened (bleached) your teeth? Y/N
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth? Y/N
10. Have you been disappointed with the appearance of the previous dental work? Y/N

Bite and Jaw Joint

11. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) Y/N
12. Do you/ would you have any problems chewing gum? Y/N
13. Do you/ would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? Y/N
14. Have your teeth changes in the last 5 years, become shorter, thinner, or worn? Y/N
15. Are your teeth crowding or developing spaces? Y/N
16. Do you have more than one bite and squeeze to make your teeth fit together? Y/N
17. Do you chew ice ,bite your nails, use your teeth to hold objects, or have any other oral habits? Y/N
18. Do you clench your teeth in the daytime or make them sore? Y/N
19. Do you have any problems with sleep or wake up with an awareness of your teeth? Y/N
20. Do you wear or have you ever worn a bite appliance? Y/N

Tooth Structure

21. Have you had any cavities within the past 3 years? Y/N
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? Y/N
23. Do you feel or notice any holes (i.e. pitting , craters) on the biting surface of your teeth? Y/N
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? Y/N
25. Do you have grooves or notches on your teeth near the gum line? Y/N
26. Have your ever broken teeth, chipped teeth, or had a toothache or cracked filling? Y/N
27. Do you get food caught between any teeth? Y/N

Gum and Bone

28. Do your gums bleed when brushing and flossing? Y/N
29. Have you ever been treated for gum disease or been told you have lost bone

around your teeth? Y/N

30. Have you ever noticed an unpleasant taste or odor in your mouth? Y/N
31. Is there anyone with a history of periodontal disease in your family? Y/N
32. Have you ever experienced gum recession? Y/N
33. Have you ever had any teeth become loose on their own(without injury), or do you have difficulty eating an apple? Y/N
34. Have you experienced a burning sensation in your mouth? Y/N

Patient's Signature_____Date_____

Doctor's Signature_____ Date_____