Springhill Dental and Orthodontics
637 NW Hickory St #110, Albany, OR 97321
(541) 406 3500
springhilldentalalbany.com

DENTAL HISTORY

Patient Name: ______________________________ **DOB:** ____________

FIRST LAST

General Information

Who was your previous Dentist and how long were you a patient there?

Date of your last dental exam:

Date of your last cleaning:

Do you have any immediate concerns you'd like us to address?

Office Relationship

What do you value most in your dental visits?

Is there anything you prefer during your visits to make you more comfortable during your time with us?

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?

Personal History

Please answer the following questions:

Question	Yes	No
Are you concerned about the appearance of your teeth?	☐ Yes	☐ No
Are you interested in improving your smile?	☐ Yes	☐ No
Have you had any cavities within the past 2 years?	☐ Yes	☐ No
Are any teeth currently sensitive to biting, sweets, hot, or cold?	☐ Yes	☐ No
Do you avoid or have difficulty chewing or biting heavily any hard foods?	☐ Yes	☐ No
Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?	☐ Yes	☐ No
Do you clench your teeth in the daytime?	☐ Yes	☐ No
Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?	☐ Yes	☐ No
Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?	☐ Yes	☐ No
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	☐ Yes	☐ No
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	☐ Yes	☐ No

Dental History

Please answer the following questions:

Question	Answer
When it comes to your oral health, do you prefer to be proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visit, money and/or pain to fix down the road?	☐ Yes ☐ No
Do you consider yourself more of a reactive person-someone who would rather wait to deal with any issues after they develop, even if that means costing you more time, visits, money and/or pain to fix down the road?	☐ Yes ☐ No
Do you know of any missing teeth or teeth that have never developed?	☐ Yes ☐ No
Have you ever had braces, orthodontic treatment, or spacers, or had a "bite adjustment?"	☐ Yes ☐ No
Are your teeth becoming more crowded, overlapped or crooked?	☐ Yes ☐ No
Are your teeth developing spaces?	☐ Yes ☐ No
Do you frequently get food caught between any teeth?	☐ Yes ☐ No
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	☐ Yes ☐ No
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	☐ Yes ☐ No
Is it often difficult to open wide?	☐ Yes ☐ No
Do you have more then one bite? Or do you notice shifting your jaw around to make your teeth fit together?	☐ Yes ☐ No
Do you prefer to break your appointments up into smaller visits or schedule out over time?	☐ Yes ☐ No
Do you prefer to get any necessary treatment done today, if possible?	☐ Yes ☐ No

Patient/Guardian Signature: ______________________ Date: 09/16/2025

Doctor Signature: ______________________