ANN MINEO KANIA Incorporation DDS, DMSc
Diplomate • American Board of Periodontology

Periodontics • Laser • Dental Implants

Dental History

What is the main reason for your visit today? _____

What is your dentist name? _____

What is the name of other periodontists that you have seen? _____

How do you feel about the appearance of your smile? _____

How important are your looks or cosmetics to you?

Not at all Important: _____ Somewhat Important: _____ Very Important: _____

Date of your last cleaning? _____ Where? _____

Have you ever had a deep cleaning or scaling and root planning? When? _____

Do your gums bleed when you brush or floss? _____

Have your teeth shifted or become loose? _____

Are your teeth sensitive to cold, heat, sweet, hot or chewing? _____

Yes	No	
☐	☐	Do you have tooth or mouth pain?
☐	☐	Are you nervous to see the dentist?
		No • Slightly • Moderately • Extremely
☐	☐	Do you clench or grind your teeth?
☐	☐	Do you have jaw clicking, popping or other sounds?
☐	☐	Do you have TMJ or jaw pain?
☐	☐	Do you have a history of past TMJ or jaw pain?
☐	☐	Do you have or have you worn partials or dentures?
☐	☐	Have you worn braces or had teeth straightened?
☐	☐	Do you wear a retainer?
☐	☐	Do you wear a night guard?
☐	☐	Do you have ulcers or mouth sores?
☐	☐	Do you experience a bad taste or bad breathe?
☐	☐	Have you had swelling, bumps or lumps in your mouth?
☐	☐	Have you had an unpleasant dental experience?

What is your history with:

Gum Surgery: _____

Braces: _____

Extractions: _____

Dental implants: _____

Root Canals: _____

Anesthesia: _____

Print Name: _____ Signature/Date: _____