DENTAL HEALTH INFORMATION

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort? ☐ yes ☐ no
If yes for how long & please describe:

____

Any sensitivity to hot, cold, sweets, chewing? ☐ yes ☐ no

Does dental treatment make you nervous? ☐ yes ☐ no

Have you experienced any of the following problems?

- Bleeding gums ☐ yes ☐ no
- Bad breath ☐ yes ☐ no
- Headaches ☐ yes ☐ no
- Grinding your teeth ☐ yes ☐ no
- Snoring ☐ yes ☐ no
- Do you use a Cpap machine? ☐ yes ☐ no

On a scale of 1 to 10, with 10 being the highest rating:

Circle one.

How important are your teeth to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your teeth and/or smile?
1 2 3 4 5 6 7 8 9 10

Do you know of treatment you need? ☐ yes ☐ no

What would keep you from doing recommended treatment?
___ Money ___ Fear ___ Time ___ Not a priority

Do you think your teeth effect your overall health? ☐yes ☐no
Do you think it is important to have your teeth cleaned at least every six months ☐yes ☐no

When was the last time you had an oral cancer exam?

____

Is the color of your teeth important to you? ☐ yes ☐ no

Do you smoke or use tobacco in any form? ☐ yes ☐ no

What beverages do you drink during the day – and how much?
Like sodas, sweet tea, etc

____

If you could change anything about your teeth –
What would that be?:

- Color ☐ yes ☐ no
- Make them straighter ☐ yes ☐ no
- Close spaces ☐ yes ☐ no
- Replace black fillings with tooth colored ones ☐ yes ☐ no
- Repair chipped teeth ☐ yes ☐ no
- Replace missing teeth ☐ yes ☐ no
- Replace old crowns or caps that don't match ☐ yes ☐ no
- Be able to chew better ☐ yes ☐ no

Do you expect to lose teeth in your lifetime? ☐ yes ☐ no

Has a dentist or hygienist ever made you feel bad about your teeth or homecare? ☐ yes ☐ no

Date of your last cleaning: ______________________

How often do you brush your teeth? ______________________

For How Long? ______________ Floss? ____________

Do you use any other products? ______________________

What is the most important thing to you about your future smile and dental health? ______________________

What is the most important thing to you about your dental visit today? ______________________