Name _____

DENTAL HEALTH

When was your last dental visit?_____ Name of Dentist _____ Phone # _____

How often did you see your dentist?_____

Are you having any dental problems that require immediate attention?_____

Do any of the following cause tooth discomfort? Hot____ Cold___ Sweets_____ Water Jet_____

How often do you brush your teeth?_____ Floss?_____ Water Jet?_____

Do your gums bleed while cleaning?_____

Do your gums ever feel tender or swollen?_____

Have you had periodontal treatment?_____ When?_____

Do you clench or grind your teeth?_____

Do your jaws ever feel tired or ache?_____ Click or pop?_____

Can you chew on both sides of your mouth?_____ Comfortably?_____

Do you have frequent headaches?_____ Earaches?_____

Have you ever had orthodontic treatment (braces)? When?_____

Do you lose fillings or break fillings?_____

Do you usually have many cavities?_____

Do you have any loose teeth?_____ Cracked or broken teeth?_____

Do you have any noticeable wear on your teeth?_____ Food traps?_____

Do you have any missing teeth?_____ Have they been replaced?_____

If so, how? Fixed bridge_____ Removable partial_____ Full denture_____ Dental implant_____

Are you comfortable with the replacement?_____ Please describe_____

Do you feel you have a problem with breath odor? _____

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

Have you ever had any cosmetic dentistry done to improve your appearance?_____

If yes, are you pleased with the result?_____ Please comment_____

Have you ever had an unpleasant dental experience?_____

Please add anything you feel is important or we can do to make your visits more comfortable_____

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