Patients Dental Health

Patients Name: ______________________ Today's Date: ______________

Why have you come in to see us today? (e.g. pain, check up, etc.) ______________________

Previous Dentist: ______________ Last Visit: ______________ Treatment Done: ______________

Reasons for changing dentists: ______________________ Date of Last Cleaning: ______________

What problems have you had with past dental treatment? ______________________

Are you nervous about seeing a dentist? ❑ Yes ❑ No If yes, please tell us why ______________________

Would you like to know about our sedation options? ______________________

How often do you brush? ______________ Do you floss ❑ Yes ❑ No How often ______________

How would you rate your overall dental health? ______ Good ______ Fair ______ Poor

Please circle each

- Y N My gums bleed while brushing or flossing.
- Y N My gums feel tender or swollen.
- Y N I have had periodontal treatment or "deep cleaning" in the past.
- Y N I often catch food between my teeth.
- Y N I would like fresher breath.
- Y N I have or have had in the past jaw pain (TMJ).
- Y N I clench or grind my teeth during the day or while sleeping.

Please circle each

- Y N I have problems eating.
- Y N I have had orthodontics.
- Y N I feel that my teeth have shifted.
- Y N I avoid brushing part of my mouth due to pain.
- Y N My mouth often feels dry.
- Y N I prefer tooth colored fillings.
- Y N I smoke or use tobacco.

Please check yes or no for each question

1. **Do you use any of the following?**
   - **Mechanical (electric) toothbrush** ______________ Yes ___ No ___
     (If yes, which brand) ______________
   - **Flossing aids (floss holders, threaders, etc.)** .... Yes ___ No ___
   - **Oral irrigating device (Waterpik)** .... Yes ___ No ___
   - **Fluoride treatments or supplements at home.** .... Yes ___ No ___
     (If yes, which brand) ______________
   - **Mouthwashes or oral rinses** .... Yes ___ No ___
     (If yes, which brand) ______________
2. **Have you ever had any complications from an extraction or dental treatment** .... Yes ___ No ___
   (If yes, please specify) ______________
3. **Have you ever had any other dental conditions, major trauma or injury to your head, neck or mouth?** .... Yes ___ No ___
   (If yes, please specify) ______________
4. **Do you feel you will eventually wear artificial dentures?** .... Yes ___ No ___
5. **Do you have any missing teeth that have not been replaced** .... Yes ___ No ___
   Why have you not had them replaced? ....
6. **Do you wear any removable dental appliances** .... Yes ___ No ___
   (If yes, how long) ______________
   Would you be interested in having it replaced? .... Yes ___ No ___
   Would you be interested in fixed (bridges or implants) rather than removable options? .... Yes ___ No ___
7. **Have you ever had your teeth whitened or bleached?** .... Yes ___ No ___
   Would you like to have your teeth whitened or bleached? .... Yes ___ No ___
8. **Would you like your teeth straighter?** .... Yes ___ No ___
9. **How do you feel about the appearance of your smile and what would you change if you could?**
   ____
10. **Are you frustrated because you always need something treated or repaired when you visit a dentist?** .... Yes ___ No ___
11. **Are you concerned about the finances required to return your mouth to excellent health or to give you the smile you desire?** .... Yes ___ No ___
12. **Anything else you feel we should know** .... Yes ___ No ___
    ____
13. **What are your dental priorities? (e.g. appearance, dental health, financial considerations, etc.)**
    ____

Doctor Notes Only: