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DENTAL HEALTH

Patient Name: ___________________________ DOB:____________ Date: _____________

Reason for today's visit: _____________________ Currently in Pain? ☐ Yes ☐ No

Last Dental Visit: ________________ Reason for last dental visit:____________________

Present / Previous Dentist: (name & location) ______________________________

How many times a **day** do you brush? ____ How many times a **week** do you floss? ____

CHECK ALL THAT APPLY

____ Cleaned within the last year
____ X-rays within the last year
____ Teeth sensitive to hot or cold
____ Teeth sensitive to sweet or sour
____ Teeth sensitive to pressure
____ Teeth feel loose
____ Catching food between teeth
____ Discomfort chewing
____ Wisdom teeth removed
____ Concerned about wisdom teeth
____ Sore gums
____ Bleeding gums
____ Dry mouth
____ Deep cleaning or gum treatments in the past
____ Prolonged bleeding in past
____ Sores, lumps in or near mouth
____ Require antibiotics before treatment

____ Wear denture or partial denture
____ Unsatisfied with smile
____ Interest in Invisalign or braces
____ Interest in cosmetic dentistry
____ Interest in whitening
____ Interest in replacing missing teeth
____ Interest in implants

____ Clenching or grinding
____ Have bite plate, nightguard, NTI
____ Nightguard recommendation by dentist
____ Difficulty opening or closing
____ Head, neck, or jaw injury in past
____ Experience pain/tenderness in jaw (TMJ)
____ Joint pain, popping jaw
____ Frequent headaches
____ Interested in sports mouthguard
____ Biting lips or cheeks
____ Hard to get numb in past
____ Bad reaction to Novocaine
____ Difficult extractions in past
____ Nervous about dental treatment
____ Difficulty leaning back
____ Choke/gag easily
____ Interest in anti-snoring appliance

____ Uses Electric Toothbrush
Brand:_____________________

Type of toothbrush:
___ Hard ___ Medium ___ Soft

____ Uses mouth rinse
Type/Brand:____________________