

# DENTAL HEALTH

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ 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  Chewing

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

Do your gums bleed while cleaning? \_\_\_\_\_

Do your gums ever feel tender or swollen? \_\_\_\_\_

Have you had periodontal treatment? \_\_\_\_\_ If so, 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  Implant

Are you comfortable with the replacement? \_\_\_\_\_ Please describe \_\_\_\_\_

How do you feel about the appearance of your smile? \_\_\_\_\_

Have you ever had an unpleasant dental experience? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at my next appointment. I authorize the release of my medical/dental information, including diagnosis and records of any treatment and examination rendered to me or the above names patient, to third party payers and/or specialists regarding dental care upon my verbal consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_