DENTAL HEALTH

Patient's Name_____

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:_____
_____

AUTHORIZATION / RECORD RELEASE

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