Dental and Oral Health Information

Patient's name: _____ **Date:** _____

Please describe any specific dental problem or discomfort you are having at this time:_____

_____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery _____

"Braces" or any type of orthodontic treatment: _____

Dental implants:_____

Any other type of oral surgery: _____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

Your Dental Health:

How do you rate your overall dental health? £ Good £ Fair £ Poor

How many times a day do you brush your teeth? _____ How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)	Yes	No
Mechanical (electric) toothbrush If Yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.)	___	___
Oral irrigating device (Waterpik)	___	___
Fluoride treatments or supplements at home. If Yes, which ones: _____	___	___
Mouthwashes or oral rinses. If Yes, what brand? _____	___	___

Do you have any missing teeth that have not been replaced? ___ ___

Why have you not had them replaced? _____

Do you wear any removable dental appliances? ___ ___

If Yes, what type and for how long? _____

Have you ever had your teeth whitened or bleached? ___ ___

Would you like to have your teeth whitened or bleached? ___ ___

How do you feel about the appearance of your smile and what would you change if you could?

_____

Are you concerned about the finances required to return your mouth to excellent health? ___ ___

Are you frustrated because you always need something treated or repaired when you visit a dentist? ___ ___

Do you feel you will eventually wear artificial dentures? ___ ___

Have you ever had any complications from an extraction or dental treatment? ___ ___

If Yes, please explain: _____

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth**?** ___ ___

If Yes, please specify: _____

If you are a new patient to this practice:

Date of last dental visit_____ Dentist's name _____City & State_____

Reviewed By: _____