DENTAL HEALTH INFORMATION

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort? ☐ yes ☐ no

Any sensitivity to hot, cold, sweets, chewing? ☐ yes ☐ no

Does dental treatment make you nervous? ☐ yes ☐ no

Have you experienced any of the following problems?

- Bleeding gums ☐ yes ☐ no
- Bad breath ☐ yes ☐ no
- Headaches ☐ yes ☐ no
- Grinding your teeth ☐ yes ☐ no
- Snoring ☐ yes ☐ no

On a scale of 1 to 10, with 10 being the highest rating:

Circle one

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health rating to be?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health effects your overall health? ☐yes ☐no

Do you think it is important to have your teeth cleaned at least every six months ☐yes ☐no

When was the last time you had an oral cancer exam? _____

Is the brightness of your teeth important to you? ☐ yes ☐ no

Do you smoke or use tobacco in any form? ☐ yes ☐ no

If you could change anything about your teeth – What would that be?

- Color ☐ yes ☐ no
- Make them straighter ☐ yes ☐ no
- Close spaces ☐ yes ☐ no
- Replace black fillings with tooth colored ones ☐ yes ☐ no
- Repair chipped teeth ☐ yes ☐ no
- Replace missing teeth ☐ yes ☐ no
- Replace old crowns or caps that don't match ☐ yes ☐ no
- Have less gum showing ☐ yes ☐ no
- Be able to chew better ☐ yes ☐ no

Do you expect to lose teeth in your lifetime? ☐ yes ☐ no

Would you like to save your teeth? ☐ yes ☐ no

Has a dentist or hygienist ever made you feel bad about your teeth or homecare? ☐ yes ☐ no

Date of your last cleaning: _____

How often do you brush your teeth? _____

For How Long? _____ Floss? _____

Do you use any other products? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____