Dental Information

For the following questions, please circle YES or NO, whichever applies. Your answers to these questions are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Date of your last dental visit _____ Date of last dental x-rays _____

Previous Dentist _____ Telephone # _____

What treatment was performed at that time? _____

What prompted you to seek dental care at this time? _____

How do you feel about the condition of your mouth? _____

How often do you have your teeth examined? _____

Has the fear of discomfort kept you from regular dental visits? .....YES NO

Are you satisfied with your previous dentistry? .....YES NO

Did either of your parents have gum disease or missing teeth? .....YES NO

Does food generally wedge between certain teeth? .....YES NO

Have you ever had any orthodontic (braces) treatment? .....YES NO

Are you teeth sensitive to hot, cold, sweets or pressure? .....YES NO

Are you aware of grinding or clenching your teeth? .....YES NO

Do you experience earaches, neck pain or TMJ pain? .....YES NO

Have you lost any teeth other than wisdom teeth? .....YES NO

Have you noticed any loose, shifted or tipped teeth? .....YES NO

Have you had any periodontal (gum) treatments? .....YES NO

When and how often do you brush your teeth? _____

When and how often do you floss or irrigate (waterpik)? _____

Are you troubled with bad breath or a bad taste in your mouth? .....YES NO

Do your gums bleed easily, feel tender or irritated, or appear red or swollen? .....YES NO

Do you wear any removable dental appliances? (partial or complete dentures, night guard, snore appliance, retainers, etc).....YES NO

Would you prefer a local anesthetic for most dental treatment? .....YES NO

Is your home water supply fluoridated? ……YES NO

Do you drink bottled or filtered water? ……YES NO

Do you have a persistent sore throat, hoarseness, earache, or feeling of something being 'caught' in your throat? ……YES NO
If yes, please provide details: _____

Have you ever been treated for oral/throat cancer?.....YES NO

Have you ever had a serious problem associated with any previous dental treatment? ……YES NO
If yes, please explain: _____

How do you feel about the appearance of your teeth? _____

Would you like any changes in the appearance of your smile? ……Yes NO
(If yes, complete the included Smile Evaluation Form)