Name_____ Date_____

Dental Information

What Is Your Reason For Seeking Dental Treatment? ___Check-up For All Necessary Dental Care? ___Dental Care For A Specific Problem? Please Explain_____

Name Of Previous Dentist_____ City/State_____

Approximate Date Of Last Dental Check-Up_____ Phone #_____

Were X-Rays Taken? ___Yes___No

Have You Ever Had:

Orthodontics	Yes___	No___
Oral Surgery	Yes___	No___
Gum Treatment	Yes___	No___
Worn A Niteguard Or Appliance	Yes___	No___

Do You Have Discomfort With Any Of The Following:

Hot Foods Or Liquids	Yes___	No___
Cold Foods Or Liquids	Yes___	No___
Sweet Foods Or Liquids	Yes___	No___
Sour Foods Or Liquids	Yes___	No___
Brushing	Yes___	No___
Flossing	Yes___	No___
Presssure when Chewing	Yes___	No___

How would you rate your dental anxiety? High___Med___Low___

Have you ever had an upsetting experience in a dental office? Yes___ No___

If so, please explain_____

What did you like least about your previous dentist?_____

What did you like most about your previous dentist?_____

Please add anything specific about dental treatment that bothers you or anything else that you feel is important.

_____

Cosmetic Evaluation

In general, are you pleased with the overall appearance of your smile and teeth?	Yes___	No___
Do you like the color of your teeth?	Yes___	No___
Do you like the shape of your teeth?	Yes___	No___
Do you like the position of your teeth?	Yes___	No___
Do you have any old fillings or dentistry that you don't like looking at?	Yes___	No___

If you could change anything about your teeth, what would it be?_____

_____

Periodontal Evaluation

Do your gums bleed when you brush your teeth, floss, or toothpick between them?	Yes___	No___
Are your gums red, swollen, or tender?	Yes___	No___
Does food tend to become caught between your teeth?	Yes___	No___
Are your gums pulling away from your teeth?	Yes___	No___
Are your permanent teeth loose or separating?	Yes___	No___
Is there any change in the way your teeth fit together when you bite?	Yes___	No___
Do you have bad breath?	Yes___	No___

How often do you brush your teeth?_____ When?_____

How often do you floss your teeth?_____ When?_____

TMJ Evaluation

Do your jaw joints make noises when you open and close your mouth?	Yes___	No___	
Do you have jaw joint pain?	Yes___	No___	
Do you have difficulty opening and closing your mouth?	Yes___	No___	
Do you ever experience headaches?	Yes___	No___	How Often?_____
Do you ever experience facial muscle tightness?	Yes___	No___	How Often?_____
Have you ever dislocated your jaw?	Yes___	No___	When?_____
Do you ever clench and grind your teeth?	Yes___	No___	When?_____