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
Teeth that are sensitive to:		
Hot, cold, sweets, or biting pressure	___	___
An unpleasant taste or persistent bad breath	___	___
Does food catch between your teeth	___	___
Do your gums bleed when brushing	___	___
Red, swollen, tender, bleeding, or sore gums	___	___
Gums that have pulled away from the teeth	___	___
Pus between the teeth and gums	___	___
Avoid any area when brushing or chewing	___	___
You clench or grind your teeth	___	___

	Yes	No
A clicking, snapping or difficulty when chewing	___	___
Difficulty opening or moving the jaws	___	___
Difficulty speaking or changes in your voice	___	___
Difficulty moving your tongue or "tongue tied"	___	___
Loose or separating teeth	___	___
Changes in the way your teeth fit together	___	___
A color change of the tissues in your mouth	___	___
Pain, tenderness, numbness, or earaches	___	___
Any lumps, swelling or swollen glands	___	___
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? ______________________	___	___

	Yes	No
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______________________

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Reviewed By: ______________________