Oral Health Status

THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE, AND IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. YOUR DENTIST WILL REVIEW THE QUESTIONS AND EXPLAIN ANY THAT YOU DO NOT UNDERSTAND. PLEASE FILL IN THE ENTIRE FORM.

1. Please describe your present concern(s) and how we can best help you:?
_____
_____
_____
_____

2. What would you like to change about your mouth, teeth, or smile?
_____
_____

3. When was your last dental examination? _____ 4. When were your last dental x-rays? _____

5. When did you last have your teeth cleaned? _____ 6. How would you rate your current oral health (1-10)? _____

Please check appropriate boxes and provide details:

7. Are you experiencing any pain or discomfort?? Yes □ No □

If yes, please explain: _____

8. Are any of your teeth sensitive to:

Heat □ Cold □ Sweet □ Pressure □

If yes, where?: _____

9. Do you have decay or need fillings replaced? Yes □ No □

If yes, please explain: _____

10. Have you ever had?

Root Canal Treatment □ Orthodontic Treatment (Braces) □ Periodontal (Gum) Treatment □

If yes, please explain: _____

11. Do you habitually chew on only one side of your mouth? Yes □ No □

If yes, which side? _____

12. Have you had surgery or major treatment for disease, injury, or condition of your face or jaws? Yes □ No □

If yes, please explain: _____

13. Have all 4 of your wisdom teeth been removed? Yes □ No □

If yes, please explain: _____

14. Are you aware of bleeding, itching, or discomfort in your gums? Yes □ No □

15. Are you aware of ever having:

Bad breath □ Foul taste □

If yes, please explain: _____

16. Do you have problems with food packing between teeth? Yes □ No □

If yes, please explain: _____

17. In your jaw joints or ears, do you notice any:

Clicking □ Popping □ Grinding Sounds □ Locking □ Pain □

18. Do you have frequent:

Headaches □ Dizziness □ Neck Stiffness □ Ear Problems □

If yes, please explain: _____

19. Do you have sleep problems?

Snoring □ Sleep Apnea □ Other □

If yes, please explain: _____

20. Do you habitually breath through your mouth? Yes □ No □

If yes, please explain: _____

21. Are you aware of grinding or clenching your teeth? Yes □ No □

If yes, please explain: _____

22. Do you notice your teeth wearing? Yes □ No □

If yes, please explain: _____

23. Are you anxious during dental treatment? Yes □ No □

If yes, please explain: _____

To the best of my knowledge, the above information is correct.

_____ _____ _____

Print Name Signature Date