Dental Health Information

Thank you for providing us with important information that will help us care for you better!

Previous Dentist: _____
Date of last dental visit/cleaning:_____

Do you have any sensitivity to hot, cold, sweets or chewing? [ ]No [ ]Yes

Does dental treatment make you nervous? [ ]No [ ]Yes

Do you use any form of tobacco? [ ]No [ ]Yes
List form:_____
Do you ever experience "dry mouth syndrome?" [ ]No [ ]Yes

Do you ever brush your tongue? [ ]No [ ]Yes

Have you ever had a periodontal or gum disease screening during a dental visit? [ ]No [ ]Yes
Do you have a history of periodontal or gum disease in your family? [ ]No [ ]Yes

Do you suffer from headaches? [ ]No [ ]Yes
How often?_____
Do you ever clench or grind your teeth? [ ]No [ ]Yes

Do you take a fluoride tablet at home? (Supplement) [ ]No [ ]Yes

How often do you brush your teeth? _____times per day. Floss: _____times per week.

What else do you do to take care of your teeth?_____

On a scale of 1 to 10, (10 being the highest rating) how would you rate your smile? Please circle:

1 2 3 4 5 6 7 8 9 10

If you would change anything about your smile what would it be? Please check all that apply:

- o Whiter Teeth
- o Straighter Teeth
- o Close Spaces
- o Replace Metal Fillings
- o Repair Chipped/Broken Teeth
- o Replace Missing Teeth
- o Replace Old Crowns/Caps that don't match
- o Repair Worn Teeth
- o Lengthen Teeth
- o Contour/Reshape Teeth

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian