DENTAL INFORMATION

Patient Name: ____
Last First MI

Primary reason for this appointment: O Examination O Emergency O Consultation

Do you have a specific dental problem today? O Yes O No

If yes, please explain: ____

Do you have dental examinations on a routine basis? O Yes O No

Last visit?: ____

Do you brush your teeth on a routine basis? O Yes O No

How often?: ____

Do you floss on a routine basis? O Yes O No

How often?: ____

Do you like your smile? O Yes O No

If no, why?: ____

Do you think you have active tooth decay? O Yes O No

Do you think you have gum disease? O Yes O No

Do your gums bleed? O Yes O No

Do you have any loose teeth? O Yes O No

Have you ever had any periodontal (gum) treatments? O Yes O No

If yes, when and where?: ____

Do you want to keep your remaining teeth? O Yes O No

Do you ever have clicking, popping, or discomfort in the jaw joint? O Yes O No

Do you brux or grind your teeth? O Yes O No

Do you smoke or chew tobacco? O Yes O No

Have you ever had orthodontic (braces) treatment? O Yes O No

Do you wear dentures or partials? O Yes O No

If yes, are you satisfied with them?: ____

Have you had any problems associated with previous dental treatment? O Yes O No

If yes, please explain: ____

Name of previous dentist (optional): ____

Date of last full mouth x-rays (16 small films or panoramic): ____