Dental Health

When was your last dental visit? _____

How often do you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot_____ Cold____

Sweets____ Chewing____

How often do you brush your teeth?_____ Floss?_____ Water Jet?_____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Do you have frequent headaches? _____ Earaches?_____

Have you ever had orthodontic treatment?(braces)_____ When? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge Removable partial Full Denture

Dental Implant Please describe _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If so, are you pleased with the result? _____

Please describe any unpleasant dental experience you have had? _____

_____

Name: _____ Date: _____