

DENTAL HEALTH INFORMATION

**Thank you for providing us with important information that will help us
to serve you better.**

Yes No

Have you experienced any of the following problems?

- | | | |
|---|--------------------------|--------------------------|
| Bleeding gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Bad breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| Soreness in jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| Grinding or clenching of teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Snoring? | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic headaches, neck aches, shoulder pains? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clenching or grinding your teeth, day or night? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain or clicking in your jaw or ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having any discomfort? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any sensitivity to hot, cold, sweets, chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does dental treatment make you nervous? | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1 to 10, with 10 being the
highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

If I could improve my smile, I would make my teeth:

- | | | |
|--|--------------------------|--------------------------|
| Whiter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Straighter? | <input type="checkbox"/> | <input type="checkbox"/> |
| Close spaces? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace black, mercury fillings with tooth colored restorations? | <input type="checkbox"/> | <input type="checkbox"/> |
| Repair chipped teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Less gums showing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Replace old crowns or caps that don't match? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you prefer to save your teeth?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health affects your overall health?
1 2 3 4 5 6 7 8 9 10

Do you think it is important to have your teeth cleaned regularly?
1 2 3 4 5 6 7 8 9 10

- | | | |
|--|--------------------------|--------------------------|
| Do you smoke or use tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink coffee or tea? | <input type="checkbox"/> | <input type="checkbox"/> |

Rate your diet's healthfulness:
1 2 3 4 5 6 7 8 9 10

How often do you brush? _____ Floss? _____ Fluoride? _____

When was your last dental visit? _____ Last oral cancer screening? _____

Reason for changing dentists? _____

Is there anything you would like us to know about your previous dental experience? _____

The above information is correct to the best of my knowledge. I authorize the dental team to perform the necessary dental services.

(Signature)

(Date)

Thank you for this information, it helps us to serve you better.

Please fax back to our office at 512-346-4079