DENTAL HEALTH SCREENING

It is important for us to have a detailed dental history so that we might better understand your needs and desires. Please complete the following to the best of your ability.

Date of last dental visit: _____
Dentist's Name: _____ City: _____ State: _____

Reason for today's visit: _____
Are you currently in pain? _____

Have you ever had a serious/difficult problem associated with previous dental work? (Please explain)
_____

Please circle the appropriate answer:

Do you wear dentures? No Partial Full
In the past how often do you have your teeth cleaned? Once/year Twice/year Other _____
Have you had periodontal (gum) treatment? Yes No If yes, date of last treatment _____

Do you require antibiotics before dental treatment?	Yes	No
Do you have any loose teeth or broken fillings?	Yes	No
Do you have any sores or growths in your mouth?	Yes	No
Does food collect between your teeth when you chew?	Yes	No
Are you aware of grinding or clinching your teeth?	Yes	No
Have you ever been told you have TMJ?	Yes	No
Do your jaws pop when chewing or yawning?	Yes	No
Have you ever had trauma to your face (i.e., auto accident)?	Yes	No
Do you feel that you have a problem with bad breath?	Yes	No
Do you use breath mints/mouth washes?	Yes	No
Have you ever bleached your teeth?	Yes	No
Have you ever worn braces on your teeth?	Yes	No
Do you feel embarrassed when you smile?	Yes	No

How many times a week do you floss? _____ A day do you brush? _____

Circle any of the following that apply:

Bleeding gums	Teeth sensitive to cold	Headaches
Tender gums	Teeth sensitive to hot	Ear Aches
Irritated gums	Teeth sensitive to sweets	Neck Pain
	Teeth sensitive to pressure	

On a scale of 0 (lowest) to 10 (highest) rate the following:

Would you like to improve the appearance of your teeth?	0 1 2 3 4 5 6 7 8 9 10
Would you like to make your smile look better or different?	0 1 2 3 4 5 6 7 8 9 10
Would you like your teeth to be whiter?	0 1 2 3 4 5 6 7 8 9 10
Would you like to keep your teeth for your lifetime?	0 1 2 3 4 5 6 7 8 9 10

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