Dental Health Information

Name: _____ **Date:** _____

We appreciate the confidence you have placed with us to provide dental care to you. All information on this form is necessary for our records and is strictly confidential. It will help us better serve you.

	Yes	No
Are you having any discomfort?	☐	☐
Any sensitivity to hot, cold, sweets, or chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐
Do you think your dental health effects your overall health?	☐	☐
Do you prefer to save your teeth?	☐	☐

Have you experienced any of the following problems? :

- Bleeding gums ☐
- Bad breath ☐
- Soreness in jaw joint ☐
- Grinding teeth ☐
- Snoring ☐

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

	Yes	No
Is the brightness of your teeth important to you?	☐	☐
Do you smoke or use tobacco in any form?	☐	☐
Do you drink coffee or tea?	☐	☐
If there were a way to whiten your teeth for a reasonable investment, would you be interested?	☐	☐
Do your gums show too much when you smile?	☐	☐
Do you have spaces between your teeth that bother you?	☐	☐
Do you have chips or uneven edges on your teeth?	☐	☐
Do you have existing crowns / dental work you consider ugly?	☐	☐
Do you avoid smiling when you have your picture taken?	☐	☐

Date of last cleaning: _____

When was your last oral cancer exam?
_____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____