Dental Health History

So that we may better serve you…

1. Do you prefer to save your teeth? [Y] [N] If yes, why? ____
2. Do you think your dental health affects your overall physical health? [Y] [N]
3. Have you received treatment for gum disease? When? How Often?_____________________________________
4. Do you drink coffee and/or tea daily? [Y] [N] If so, how much per day? ______________________________
5. Have you experienced any of the following problems:
   Bleeding gums [Y] [N], Bad Breath or sour taste in mouth [Y] [N] Snoring [Y] [N]

   Soreness in jaw [Y] [N], Is it hard for you to open wide? [Y] [N] Grinding of Teeth [Y] [N
6. Do your muscles hurt or get tired when you hold your mouth open for a long time? [Y] [N]
7. Do you have headaches? When? How often? What time of day? [Y] [N] _________________________________
8. Are you sensitive to sweets / cold / hot? Which? [Y] [N] ____
9. Do you smoke or chew? How much? [Y] [N] ____
10. What type of toothpaste do you use? Do you Floss? How often?_____________________________________
11. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? ________
    ____
12. Have you ever been hit in the mouth? When? [Y] [N] ____
13. Are you feeling any more stress or anxiety in your life now, then in the past? [Y] [N]
14. Is the brightness of your teeth important to you? [Y] [N]
15. Do you think it is important to have your teeth cleaned at least 2 x's a year? [Y] [N]
16. Have you ever had an oral cancer exam done? [Y] [N] If yes, when was the last time? ____________________
17. If you could change anything about your smile you might want to change the following?
    Whiter [Y] [N], Straighter [Y] [N], Close space or spaces [Y] [N], Replace chipped teeth [Y] [N],
    Replace missing teeth [Y] [N] Less Gum showing [Y] [N], Replace old crowns [Y] [N]

Rate the following on a scale of 1 to 10 with 10 being the highest

1. Where would you rate your overall oral health and/or the appearance of your smile?
2. How important is your dental health to you? Very important Somewhat important Not important
3. How would you rate your current dental health? Where would you like it to be?

Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years? ____
____
____

Please rate the following in importance to help you with your dental health decisions
1 to 10 with 10 being the highest.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

Tell us about You…..

Full Name____Phone Number __________________

Address ___________________________________City ___________State _____Zip __________

Date of Birth _______________________________S.S. Number __________________________

Employer __________________________How Long? ___ Occupation ______________________

Work Number _____________Cellular Phone _____________ Pager __________

Marital Status: S M D W C E-Mail Address ________________________________

WHOM MAY WE THANK FOR REFERRING YOU?____________________________________

IN CASE OF EMERGENCY, CONTACT ……

Name ________________________________Relation _______________Home Number _______

Address____ Work Phone ___________

Health Questions …..

Have you ever had:

	Yes	No		Yes	No
Asthma	__	__	Arthritis	__	__
Allergies or Hives	__	__	Kidney or Bladder Disease	__	__
Tuberculosis	__	__	Hepatitis, Cirrhosis, Liver Disease	__	__
Stroke	__	__	Epilepsy or Seizures	__	__
Heart Disease or Attack	__	__	Diabetes	__	__
Angina Pectoris	__	__	Blood Transfusion	__	__
High Blood Pressure	__	__	Abnormal Bleeding Tendencies	__	__
Pacemaker	__	__	HIV Infection or AIDS	__	__
Heart Murmur	__	__	Sickle Cell Disease or Trait	__	__
Rheumatic Fever	__	__	Stomach or Intestinal Ulcers	__	__
Mitral Valve Prolapse	__	__	Chemo or Radiation Treatment	__	__
Joint Replacement	__	__	Fainting or Dizzy Spells	__	__
Latex Sensitivity	__	__	Women: Are you Pregnant?	__	__

Physician's Name __________________________Specialty ____________City______________

Are you being treated by a physician now? ☐ Yes ☐ No For what reason (s)?____________________
____

Are you taking any medications at the present time? ☐ Yes ☐ No Which medication (s)?___________
____

Are you sensitive or allergic to any medications? ☐ Yes ☐ No Which medication (s)?_____________

Have you ever been hospitalized? ☐ Yes ☐ No List reasons:__________________________________

May we have permission to use your pictures for our web site and educational purposes ☐ Yes ☐ NO

Dental Health History

So that we may better serve you…

1. Do you prefer to save your teeth? [Y] [N] If yes, why? ____
2. Do you think your dental health affects your overall physical health? [Y] [N]
3. Have you received treatment for gum disease? When? How Often? ______________________________________
4. Do you drink coffee and/or tea daily? [Y] [N] If so, how much per day? _____________________________
5. Have you experienced any of the following problems:
   Bleeding gums [Y] [N], Bad Breath or sour taste in mouth [Y] [N] Snoring [Y] [N]

   Soreness in jaw [Y] [N], Is it hard for you to open wide? [Y] [N] Grinding of Teeth [Y] [N
6. Do your muscles hurt or get tired when you hold your mouth open for a long time? [Y] [N]
7. Do you have headaches? When? How often? What time of day? [Y] [N]_________________________________
8. Are you sensitive to sweets / cold / hot? Which? [Y] [N] ____
9. Do you smoke or chew? How much? [Y] [N] ____
10. What type of toothpaste do you use? Do you Floss? How often? ______________________________________
11. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you?_______
    ____
12. Have you ever been hit in the mouth? When? [Y] [N] ____
13. Are you feeling any more stress or anxiety in your life now, then in the past? [Y] [N]
14. Is the brightness of your teeth important to you? [Y] [N]
15. Do you think it is important to have your teeth cleaned at least 2 x's a year? [Y] [N]
16. Have you ever had an oral cancer exam done? [Y] [N] If yes, when was the last time? ____________________
17. If you could change anything about your smile you might want to change the following?
    Whiter [Y] [N], Straighter [Y] [N], Close space or spaces [Y] [N], Replace chipped teeth [Y] [N],
    Replace missing teeth [Y] [N] Less Gum showing [Y] [N], Replace old crowns [Y] [N]

Rate the following on a scale of 1 to 10 with 10 being the highest

1. Where would you rate your overall oral health and/or the appearance of your smile?
2. How important is your dental health to you? Very important Somewhat important Not important
3. How would you rate your current dental health? Where would you like it to be?

Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years? ____
____
____

Please rate the following in importance to help you with your dental health decisions 1 to 10 with 10 being the highest.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology