DENTAL INFORMATION

Patient Name: _____ Sex: _____ Height: _____ Age: _____

What is the reason of your dental visit? _____

When was your last dental visit? _____ Previous Dentist Name: _____

Previous Dentist Address: _____ Tel #: _____

Does dental treatment make you nervous? Yes ❑ No ❑

If yes, please explain: _____

Do you like the overall appearance of your teeth? Yes ❑ No ❑

Do you consider that your teeth are in good alignment? (straight) Yes ❑ No ❑

If no, please describe _____

Do you like the color of your teeth? Yes ❑ No ❑

If no, please describe _____

Do your teeth have unattractive stains? Yes ❑ No ❑

❑ Coffee, tea stains ❑ Silver fillings stains ❑ Tobacco stains

❑ Discolored fillings ❑ Tetracycline stains ❑ Other

Do you like the shape of your teeth? Yes ❑ No ❑

If no, please describe _____

Do you think your teeth are attractive? Yes ❑ No ❑

❑ Chipped ❑ Overlapping ❑ Hidden ❑ Protruding

❑ Excessively worn ❑ Artificial-looking

Have you ever had your teeth whitened or bleached? Yes ❑ No ❑

Do you consider your existing fillings or dental work as unattractive? Yes ❑ No ❑

If yes, please describe _____

Do you think your gums are

❑ Swollen ❑ Excessively receded ❑ Bleed easily ❑ Red, inflamed

❑ Crowns are ill-fitted ❑ Difficult to clean between your teeth

Do you grind your teeth while sleeping, exercising, etc.? Yes ❑ No ❑

Do you experience jaw clicking? Yes ❑ No ❑

Do you experience ear / joint pain? Yes ❑ No ❑

Do you have sensitivity to cold, hot, sweet or pressure to any of your teeth? Yes ❑ No ❑

Do you notice yourself with halitosis (bad breath)? Yes ❑ No ❑

Have you ever been diagnosed with periodontal disease? Yes ❑ No ❑

Have you in the past needed to premedicate prior to dental appointment? Yes ❑ No ❑

Do you have dry mouth (Xerostomia)? Yes ❑ No ❑

Do you bite your lip or cheek? Yes ❑ No ❑

Do you have blisters on your lip or mouth? Yes ❑ No ❑

Do you presently have any dental implants? Yes ❑ No ❑

Do you presently have any crown / bridge work? Yes ❑ No ❑

Are you interested in veneers? Yes ❑ No ❑

How often do you brush your teeth? ___ times per day ___ times per week

How often do you floss? ___ times per day ___ times per week

How often do you use fluoride rinse? ___ times per day ___ times per week

Are you allergic or have reacted adversely to local anesthetics? Yes ❑ No ❑

Are you allergic to Latex? Yes ❑ No ❑

Have you had any serious trouble associated with previous dental treatment? Yes ❑ No ❑

If yes pls. describe: _____

Signature of the Parent, Guardian or Patient _____ Date: _____

Signature of the Dentist _____ Date: _____