

ORAL HEALTH / DENTAL INFORMATION

Name of **previous dentist** _____ Date of last visit _____

Of what has your **past** dental care consisted? _____

What are your **current** dental concerns? _____

Please check the conditions below that **currently or commonly apply** to you:

____ tooth pain or sensitivity ____ gum bleeding or swelling ____ gum recession ____ bad breath ____ mouth sores
____ broken or lost fillings ____ food gets stuck between teeth ____ jaw pain ____ jaw noises ____ frequent headaches
____ difficulty chewing ____ difficulty opening or closing jaw
others? _____

Have you **ever had or do you now** have:

____ periodontal disease ____ night-guard or other mouth guard ____ braces ____ retainers ____ fillings
____ teeth extracted ____ root canal therapy ____ jaw injury ____ serious head injury ____ cosmetic dentistry
others? _____

How would you describe your **oral health**: _____

and circle 1 2 3 4 6 7 8 9 10 (1 is poor, 10 is excellent)

How would you describe the **way your teeth look**: _____

and circle 1 2 3 4 6 7 8 9 10 (1 is poor, 10 is excellent)

Describe how any oral condition may be affecting your general health or have you ever experienced physical symptoms following dental treatment: _____

Please describe your oral hygiene practices: _____

What, if any, past experiences in dental offices would you like to avoid in the future? _____

What, if any, specific steps could we take that would make your experience in our office more comfortable? _____

What other information would you like us to know so that we can better serve you? _____

Thank you for filling out these forms. The more we know about you, the better we can serve you. We are honored to be part of your journey of health.