DENTAL INFORMATION

How often do you brush your teeth?

_____

How often do you floss your teeth?

_____

Do your gums bleed while brushing or flossing? ❑ Y ❑ N

Are your teeth sensitive to hot or cold liquids/foods? ❑ Y ❑ N

Are your teeth sensitive to sweet or sour liquids/foods? ❑ Y ❑ N

Do you feel pain to any of your teeth? ❑ Y ❑ N

Do you have any sores or lumps in or near your mouth? ❑ Y ❑ N

Have you had any head, neck or jaw injuries? ❑ Y ❑ N

Have you ever experienced any of the following problems with your jaw?

- ❑ Clicking
- ❑ Pain (joint, ear, side of face)
- ❑ Difficulty in opening or closing
- ❑ Difficulty in chewing

Do you have frequent headaches? ❑ Y ❑ N

Do you clench or grind your teeth? ❑ Y ❑ N

Do you bite your lips or cheeks frequently? ❑ Y ❑ N

Have you noticed any loosening of your teeth? ❑ Y ❑ N

Does food tend to become caught between your teeth? ❑ Y ❑ N

Have you ever had periodontal treatment (gums)? ❑ Y ❑ N

Have you ever worn a bite plate or other appliance? ❑ Y ❑ N

Do you wear dentures or partials? ❑ Y ❑ N
If yes, date of placement

_____

Have you ever received oral hygiene instruction in regard to the care of your teeth and gums? ❑ Y ❑ N

If you could change anything about your smile, what would you change?

_____

_____

_____

_____

_____

_____

On a scale of 1-10 how would you rate your smile?

_____