

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?
