## PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: routine checkup, pain, etc.)
_____

Previous Dentist _____

Last Visit Date of last cleaning and x-rays
_____

What problems have you had with past dental treatment?
_____

Are you nervous about seeing a dentist? ❑ Yes ❑ No
If yes, please tell us why:
_____

How often do you brush? _____

Do you floss? ❑ Yes ❑ No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.

Y N My gums feel tender or swollen

Y N My gums bleed while brushing or flossing.

Y N I have problems eating.

Y N I like my smile.

Y N I have had a facial or jaw injury.

Y N I avoid brushing part of my mouth due to pain.

Y N I have had orthodontics.

Y N I want my teeth straight.

Y N I want my teeth whiter.

What are your dental priorities? *(e.g.: appearance, dental health, financial considerations, etc.)*

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