Your Dental Assessment

This could be the most important dental visit of your life. Here's why: here at The O'Leary Dental Office, we provide complete care for you with the goal of minimizing the amount of time you will need to spend in a dental chair – for the rest of your life. We can do this by helping you determine your current - *and* your future dental needs. Here are some things we are going to be talking about at your first visit. A few of these items might be topics that you have never considered with regard to your dentistry.

1) Are you currently concerned with any specific area or condition in your mouth.

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2) In your opinion, what is the present state of the health of your mouth?

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3) Please name any family or friends that are already clients of Dr. O'Leary:

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4) How healthy would you like for your mouth to be if you were to complete care here?

*I don't really care. * Average. *Ideal/The best it can be.

5) Should you need treatment, at what point should we address it?

*When my tooth hurts/breaks. *When something worsens.
*When something isn't ideal.

6) What quality of dentistry do you want to receive?

*A patch or quick repair. *Average. *Ideal/The best.

7) Dr. O'Leary has the ability to look at your mouth from 3 different perspectives.
In what order shall he address your needs?

(Please number your preferred order 1-3.)
___ As a general dentist. ___ As a cosmetic dentist. ___ As a TMJ dentist.

8) Has fear ever been an issue for you in a dental office?

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9) What caused you to leave your last dental office?

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10) Has the cost of dental treatment been a concern for you?

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11) Does food pack or catch between your teeth?

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12) Does floss shred when you use it?

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13) Are any of your teeth loose?

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14) Do you clench your teeth?

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15) Do your gums bleed?

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16) Have you ever had sensitivity to latex?

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17) Do you or have you been grinding your teeth?

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18) Does your breath concern you?

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19) Do you have sensitive teeth?

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20) Have you had braces or orthodontic treatment?
When? ________________ Dr.'s Name ______________________________________

21) Is there any additional information that you would like for us to know about?

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Patient Signature: ____

Date: ____