**PATIENT’S NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL CARE**

 Are you currently under a Dentist’s Care**?**  **YES / NO**  If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of the DENTIST that provided care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental X-rays: 6 mo. / 1 yr / \_\_\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other dental aids do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ( examples: Electric toothbrush, flosser, tooth pick, etc…..)

Do you wear dentures? **YES / NO** **PARTIALS / FULL**

 Are you happy with your dentures? **YES / NO** Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLACE A CHECK MARK NEXT TO THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:**

□ Gum Disease □ Discolored teeth

□ Decay □ Loose teeth

□ Bad Breath □ Tired jaws, especially in the morning

□ Cold sores, blisters or oral lesions □ Broken Jaw

□ Prolonged bleeding either from a cut or dental procedure □ Difficulty getting numb

□ Headaches □ Ear aches

□ Neck pain □ Bleeding gums

□ Gums feel tender □ Gums feel tender or irritated

**PLACE A CHECK MARK NEXT TO THE DENTAL TREATMENT WHICH YOU HAVE HAD:**

□ Orthodontic Treatment (Braces)

□ Teeth Extraction

□ Missing Teeth with No Replacement

□ Periodontal Treatment ( Treatment for gum disease, gum regenerative procedures, gum surgery)

□ Endodontic Treatment ( Root Canals )

□ Bite Adjustment

□ General Anesthesia

□ Cortisone Injections into the joints

**PATIENT’S NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLACE A CHECK MARK NEXT TO THE HABITS YOU FIND YOURSELF DOING:**

 □ Clench or grind your teeth □ Bite your cheeks □ Bite your nails □ Chew Gum often □ Other Oral Habits ( ie: pencil biting ) □ Bite on your front teeth first

 □ Get food caught between your teeth

**PLACE A CHECK MARK NEXT TO THE THINGS YOUR TEETH ARE SENSITIVE TO:**

 □ Hot □ Cold □ Sweets □ Biting and Chewing □ No Sensitivity

**DENTAL CARE ASSESSMENT : Please answer the questions below by CIRCLING your answer.**

**Are you happy with the general appearance of your teeth?** YES / NO

**--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**Do you want your smile to look better or different in any way?** YES / NO

**--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**How healthy would you like your mouth to be if you were to complete dental care here?**

 I do not really care ; Average ; Ideal

**--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

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

 When my tooth hurts or breaks ; When something worsens ; As soon as problem is identified

**--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**What quality of Dentistry do you want to receive?**

 A patch or quick repair ; Average ; Ideal

 --------------------------------------------------------------------------------------------------------------------------------------

**Rank in order 1 – 4 what would keep you from having dental treatment?**

 (#1 being the most important)

 #\_\_\_\_Fear ; #\_\_\_Cost of treatment ; #\_\_\_Missing work ; #\_\_\_Lack of Concern for teeth

**INJURIES TO THE MOUTH/ JAW/ TEETH**

Have you had any accidents or injuries? ( includes: sports, slips, falls or auto) **YES / NO**

If yes, an approximate date of when it happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 A brief summary of what happened:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If dental treatment was performed, please provide a brief summary of what was done:

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature or Guardian’s Signature Date**