DENTAL HEALTH INFORMATION

PATIENT NAME: ______________________ Date_______

Thank you for providing us with important information that will help us serve you better.

	YES	NO
Are you having any discomfort?		
Any sensitivity to hot, cold, sweets, chewing?		
Does dental treatment make you nervous?		
Have you experienced any of the following problems:		
Bleeding gums		
Bad breath or sour taste in mouth		
Soreness in jaw joint		
Grinding of teeth		
Snoring		

CIRCLE A NUMBER FOR YOUR ANSWER:
On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Do you think it is important to have your teeth cleaned at least twice a year?

Did you have an oral cancer exam done at your last cleaning appointment?

	YES	NO
Is the brightness of your teeth important to you?		
Do you smoke or use tobacco in any form?		
Do you drink coffee or tea daily?		
If I could change my smile I would like my teeth:		
Whiter		
Straighter		
Close space or spaces		
Replace chipped teeth		
Replace missing teeth		
Less gum showing		
Replace old crowns or caps that don't match		
Do you prefer to save your teeth?		
Have you ever had a special coating applied to your back teeth to protect them from tooth decay?		
Do you take fluoride supplements?		
Do you think your dental health affects your overall physical health?		
When was the last time you had your teeth cleaned?		
Would you be interested in whitening your teeth?		

Where do you see yourself and your overall oral health and/or smile in the next 5-10 years? ____

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What is the most important thing you want Dr. Sana to know about your dental visit today? ____

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