

## Dental History

The following questions are intended to help better analyze your current dental health and initiate conversation about care you have or have not been introduced to in the past.

Have you receive regular dental care in the past (at least once a year?)	Yes	No	
Approximately when was your last dental exam?	_____		
Do you experience dental anxiety?	Yes	No	
If yes, to what degree?                      Mild                      Moderate	Severe		
Would you be interested in sedation dentistry?	Yes	No	
What kind of tooth Brush do you use? Circle one	Electric	Manual	
When do you brush your teeth?	AM	PM	Both
How long do you spend brushing?	_____		
Do you use a mouth rinse?	Yes	No	
How often do you floss?	Daily	Irregularly	Never
Do your gums bleed when you brush?                      Yes                      No	When you floss? Yes	No	
Do you feel you have problems with Breath odor, chew gum or use mints regularly?	Yes	No	
Do you have any teeth that are hot or cold sensitive?	Yes	No	
Do you have any teeth that are sweet sensitive?	Yes	No	
Do you have pain in your mouth?	Yes	No	
Do you have any teeth that are painful to biting pressure?	Yes	No	
Do you have frequent headaches in your forehead or temples region?	Yes	No	
Do you experience frequent jaw soreness?	Yes	No	
Do you have difficulty in opening your mouth?	Yes	No	
Do your jaw joints pop?	Yes	No	
Do you have any difficulty in chewing?	Yes	No	
Have you ever worn braces before?	Yes	No	
If so are you happy with your orthodontic outcome?	Yes	No	
If not, would you consider orthodontic care if you did not have to wear braces	Yes	No	
Are you missing any teeth other than wisdom teeth or teeth removed for orthodontic purposes?	Yes	No	
If so, have the benefits of replacement been explained to you?	Yes	No	
Are you open to options to replace the tooth or teeth?	Yes	No	
Do you like the way your teeth look?	Yes	No	
Do you currently use any over the counter teeth whitening products?	Yes	No	
If yes, what product? _____			

This office offers some Spa features. Please circle any services that you would like more information about:

- |                            |                       |                           |                |
|----------------------------|-----------------------|---------------------------|----------------|
| Botox                      | Restylane             | Juvederm                  | MassageTherapy |
| Microdermabrasion          | Power Teeth Whitening | Invisalign (clear braces) |                |
| Silent night - snore guard |                       |                           |                |