|  |
| --- |
| Patient Name: |
| On a holistic scale from 1-10 how rate your overall health? |
| Why are you seeking dental treatment? |
| Have you been to a dentist? If yes. How long ago? |
| What was done?  |
| Name of Dentist? Dentist Phone: |
| Did you have any dental x-rays taken in the last 2 years? |
| When was your last cleaning? |
| How often did you visit a dentist before your last visit? |
| How often do you brush your teeth? | How often do you floss? |

**Please CIRCLE: Yes or NO for the following questions, If you are unsure, PLEASE DO NOT Answer.**

|  |  |  |
| --- | --- | --- |
| Yes | No | Do you use anything else to clean your teeth and Gums? |
| Yes | No | Are you satisfied with appearance of your teeth? |
| Yes | No | Have you ever had your teeth straightened? |
| Yes | No | Have you experienced any complications with extractions? |
| Yes | No | Are any of your teeth sensitive to hot? |
| Yes | No | Are any of your teeth sensitive to cold? |
| Yes | No | Are any of your teeth sensitive to sweets? |
| Yes | No | Are any of your teeth sensitive to chewing? |
| Yes | No | Do you have bleeding gums? |
| Yes | No | Does food wedge between your teeth? |
| Yes | No | Do you grind your teeth? |
| Yes | No | Have you ever had gum treatments? |
| Yes | No | Do you snore loudly? ( louder than talking loud enough to be through closed doors)? |
| Yes | No | Do you often feel tired, fatigued or sleepy during the day? |
| Yes | No | While sleeping, Has anyone observed you stop breathing while sleeping? |
| Yes | No | Do you feel you have bad breath? |
| Yes | No | Have you ever noticed an unpleasant taste in your mouth? |
| Yes | No | Does your jaw frequently pop or click? |
| Yes | No | Do you have any nasal obstruction? |
| Yes | No | Have you had any sores in your mouth? |
| Yes | No | Do you have any difficulty opening your mouth? |
| Yes | No | Do you have any difficult chewing? |
| Yes | No | Are you aware of any swelling or lump under your chin or along your neck? |
| Yes | No | Are you aware of any swelling or lump in your mouth? |
| Yes | No | Are you happy with your previous dental work? |
| Yes | No | Were there any complications or problems with your last dental treatment?  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Notes: