Dental Health Information

Name___________________________________

	YES	NO		YES	NO
Are you having any discomfort?			Do you drink coffee or tea?		
Any sensitivity to hot, cold, sweets, or chewing? Circle all that apply.			Do you use oral tobacco in any form? Specify.		
If I could change my smile I would make my teeth:			Have you experienced any of the following problems?		
Whiter			Bleeding gums		
Straighter			Bad breath		
Close a space/spaces			Soreness in jaw/TMJ		
Repair chipped teeth			Grinding of teeth		
Replace silver/amalgam fillings with tooth colored restorations					
Replace missing teeth with bridges/implants?					
Replace crowns that do not match surrounding teeth			Have you ever been diagnosed with gum/Periodontal Disease?		
Have less gum tissue showing			Have you ever sought treatment or been told to seek treatment from a Periodontist/gum specialist?		

What is the most important thing to you about your smile and dental health?

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Are there any specific procedures you are interested in?

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What can we do in our office to make your visits more comfortable?

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