

DENTAL HEALTH HISTORY

66. Name of Previous Dentist: _____ How long since you were last seen? _____

67. Is keeping your teeth important to you? [Y] [N] If yes, why? _____

68. On a scale of 1-10, 10 being the best, where would you rate your smile?

69. On a scale of 1-10, 10 being the best, where you rate your oral health?

70. Have you experienced any of the following problems:

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|---|--|
| Bleeding gums [Y] [N], | Sensitivity to Hot & Cold [Y] [N] |
| Bad Breath or sour taste in mouth [Y] [N] | Snoring [Y] [N] |
| Burning sensations in mouth [Y] [N] | Food catching between teeth [Y] [N] |
| Soreness in jaw [Y] [N], | Grinding of Teeth [Y] [N] |
| Is it hard for you to open wide? [Y] [N] | Pain/soreness around ears, eyes, face [Y] [N] |
| Clicking or popping in jaw [Y] [N] | Stiff neck muscles [Y] [N] |
| Had your parents suffered from Gum Disease? [Y] [N] | Did you parents wear dentures/partials? [Y] [N] |
| Did you ever wear braces? [Y] [N] | Ever been injured in your mouth or head? [Y] [N] |
| Oral Surgery of any kind? [Y] [N] | Do you smoke or chew tobacco? [Y] [N] |

71. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

72. Is the brightness of your teeth important to you? [Y] [N]

73. If you could change anything about your smile which of the following would you want to change?

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|--------------------------------------|---------------------------------|--|
| Whiter [Y] [N], | Close space or spaces [Y] [N] | Replace chipped teeth [Y] [N] |
| Replace missing teeth [Y] [N] | Replace old crowns [Y] [N] | Remove silver fillings [Y] [N] |
| Remove Stains/Spots on teeth [Y] [N] | Excess showing of Teeth [Y] [N] | Replace old plastic filling(s) [Y] [N] |
| Straighter [Y] [N] | Less Gum showing [Y] [N] | Reshape/resize my teeth [Y] [N] |

74. Fill in this question for us please: Where do you see yourself and your overall oral health and/or your smile in the next 5 to 10 years?

Please circle the following, which are important to you when making your dental health decision.

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|-----------------------|------------|---------------------------------|
| Convenience | Appearance | Relationship with Dental Team |
| Finances | Time | Quality of care |
| What insurance covers | Health | Detailed treatment explanations |
| Fear or Anxiety | Comfort | Technology |