DENTAL HEALTH

When was your last dental visit? _______________ How often did you see your dentist? ________________

Are any teeth bothering you? ____

Do any of the following cause tooth discomfort? Hot _______ Cold _______ Sweets _______ Chewing ______

What do you use to clean your teeth? _________________________ How many times per day? ____________

Do your gums bleed while cleaning? _____________ Do your gums ever feel tender or swollen? ____________

Do you clench or grind your teeth? ____

Do your jaws ever feel tired or ache? _____________________ Click or pop? ____________________________

Do you have frequent headaches? ________________________ Earaches? _____________________________

Have you ever had braces? ____

Have you had your "wisdom" teeth removed? ________ Any complications? ____________________________

Are you missing any teeth? ___________________ Have they been replaced? ____________________________

If not, have you ever considered replacing them? ____

Do you have any food traps? ____

Have you sustained any trauma to teeth, mouth, or jaw? ____

If so, please provide details____

Thumb Habit? ________________ Pacifier? ________________________ Mouth Breather? _________________

How is your water supplied to your home? (Circle ONE) Well Public Water Cistern

Please list any fluoride supplements used ____

Do you use tobacco products? ________ If so, what do you use? _______________ How often? ______________

Is there anything you would like to change about your smile?

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Please add anything you feel is important: ____

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Signature: ____