Current Dental Status

Clinton Smiles!

Name _____ Date _____

In order for us to best serve your dental needs, we would appreciate the below information:

What is the most important thing we can do for you today?_____
_____

What is most important to you in a dentist? _____
_____

What are your expectations of our office? _____
_____

What did you like the best about your previous dentist? _____
_____
What did you like the least: _____
_____
What would you like to change about the appearance of your teeth? _____
_____

Your current dental health is: _____Good _____Fair _____Poor
Date of your last dental visit _____ Date of last Dental Cleaning _____
Date of Last Full Mouth Series _____ Previous Dentist _____
Have you ever had a serious/difficult problem associated with any previous dental work?_____Yes _____ No
Do you have any areas in your mouth that concern you now? _____
_____

Are any of your teeth sensitive to :

Hot ____
Cold ____
Sweets ____
Pressure ____

Have you ever had:

Orthodontic Treatment ____
Oral Surgery ____
Periodontial Treatment ____
Your bite adjusted ____

Do you floss daily? _____ Do you brush daily? _____
Do you still have wisdom teeth? _____ Yes _____No
Have you noticed:

- Loosening of your teeth? ____ Yes _ ____ Yes _____No
- Food catching between your teeth? _____Yes _____ No
- Pain/swelling of your gums? ____ Yes _____No
- Gums ever bleed when you brush/floss? ____ Yes _____No
- Bad Breath? ____ Yes _____No
- Sore areas in your mouth? ____ Yes _____No

Have you ever been told you have periodontial disease ?
_____Yes _____No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMD/TMJ)? _____Yes _____No

Thank you!