INITIAL EXAM- PATIENT DENTAL QUESTIONS

DATE: _____

Patient Name: _____ **Preferred Name:** _____

Initial Concern: _____

Date of Last Dental Cleaning:_____ **Date of Last Full Mouth Series of X-rays:**_____

YES	NO	
☐	☐	**Are you having pain at this time?**
		Have you ever had:
☐	☐	Orthodontic Treatment?
☐	☐	Oral Surgery?
☐	☐	Periodontal Treatment?
☐	☐	Your Teeth smoothed or Bite adjusted?
☐	☐	Have you ever worn a bitesplint or other appliance?
☐	☐	Have you noticed any loosening of your teeth?
☐	☐	Does food tend to become caught between your teeth?
☐	☐	Do you suffer from pain and/or swelling of your gums?
☐	☐	Do your gums often bleed when you brush your teeth? ☐
		Problems of the jaw. Have you experienced:
☐	☐	Clicking of the jaw?
☐	☐	Pain (Joint, Ear, Side of Face)?
☐	☐	Difficulty in opening or closing?
☐	☐	Difficulty in chewing?
		Habits, Do you:
☐	☐	Clench or grind teeth while awake or asleep?
☐	☐	Bite your lips or cheeks regularly?
☐	☐	Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, pens)?
☐	☐	Mouth Breath while awake or asleep?
☐	☐	Do you feel very nervous about having dental treatment?
☐	☐	Have ever had an upsetting experience in a dental office?
☐	☐	Is it important to keep your teeth?
☐	☐	Are you dissatisfied with the appearance of your teeth? If yes please explain: _____

_____

_____