Dental and Oral Health Information

DAVID D. HAYES, D.D.S.

Patient's Name: _____ **Date:** _____

Please describe any specific dental problems or discomfort you are having at this time: _____

_____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: _____

"Braces" or any type of orthodontic treatment: _____

Dental implants: _____

Any other type of oral surgery: _____

Do you have/have you had/have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	**Yes**	**No**		**Yes**	**No**
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between your teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

Your Dental Health:

How do you rate your overall dental health? ❑ Good ❑ Fair ❑ Poor

How many times a <u>day</u> do you brush your teeth? _____ **How many times a <u>week</u> do you floss your teeth?** _____

Do you use any of the following? (Please check Yes or No for each question)	**Yes**	**No**
Mechanical (electric) toothbrush. If Yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.)	___	___
Oral irrigating device (Waterpik)	___	___
Fluoride treatments or supplements at home. If Yes, which ones: _____	___	___
Mouthwashes or oral rinses. If Yes, what brand? _____	___	___
Do you have any missing teeth that have not been replaced?	___	___
Why have you not had them replaced? _____		
Do you wear any removable dental appliances?	___	___
If Yes, what type and for how long? _____		
Have you ever had your teeth whitened or bleached?	___	___
Would you like to have your teeth whitened or bleached?	___	___

How do you feel about the appearance of your smile and what would you change if you could?

_____

Are you concerned about the finances required to return your mouth to excellent health?	___	___
Are you frustrated because you always need something treated or repaired when you visit a dentist?	___	___
Do you feel you will eventually wear artificial dentures?	___	___
Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth?	___	___
If Yes, please specify: _____		

If you are a new patient to this practice:

Date of last dental visit: _____ Dentist's name: _____ City & State _____

Reviewed By: _____