# *Oak Ridge Family Dental*

## *Dental History:*

What is the reason for today's visit? _____

Date of last exam? _____ How often do you floss? _____

Current dental problems?_____ Previous Dentist's Name? _____

Have you ever had an upsetting dental experience? ___ Yes ___ No Please describe: _____

_____

Are you happy with the appearance of your teeth? ___ Yes ___ No Please Explain:

_____

What characteristic do you feel is the most important to you in your dental treatment? (Choose 1 or 2)

_____ Expense _____Pain/Comfort _____ Esthetics _____ Function _____ General Health _____ Prevention

## *Please check all that apply to you:*

___ I have family members with dentures or partials

___ My gums bleed when flossing

___ Floss < 5 times weekly

___ Routine bad breath

___ Smoke or use tobacco products

___ Dry mouth

___ Diabetes

___ Red swollen gums

___ Stress

___ Osteoporosis

___ Loose teeth

___ Frequent build up on teeth

___ I have had a "deep cleaning" in the past

___ I drink soda, energy drinks, Gatorade or juice

___ I eat sweets

___ I have had fillings placed in the past three years

___ I drink coffee with sugar (not substitute)

___ I have broken a tooth in the past

___ I have had a crown come off

___ I have chipped porcelain in my mouth

___ My teeth are wearing short in the front

___ My teeth are sensitive to cold

___ I wake up with tightness in my jaw

___ I have been told I grind my teeth

___ I get frequent headaches or neck aches

___ I have tired jaws in the morning

___ I have difficulty opening or closing my mouth

___ I have clicking or popping in my jaw

___ Cold sensitivity

___ Hot sensitivity

___ Sensitivity when biting

___ Sensitivity to sweets

___ Sores or growths in your mouth

___ Bleeding gums