DENTAL INFORMATION

Yes	No		
❑	❑	1.	Have you ever had an upsetting experience in the dental office?
❑	❑	2.	Is there anything about having dental treatment that bothers you?
❑	❑	3.	Do you have problems being reclined in a dental chair?
❑	❑	4.	Is it important for you to keep your teeth?
❑	❑	5.	Are you dissatisfied with the appearance of your teeth?
❑	❑	6.	Are you dissatisfied with the function of your teeth?
❑	❑	7.	Interested in teeth whitening?
❑	❑	8.	Have you tried whitening products?
❑	❑	9.	Do you want Nitrous Oxide (laughing gas)?
❑	❑	10.	Have you had Nitrous Oxide before?
❑	❑	11.	Do you get dry mouth?
❑	❑	12.	Do you get bad breath or unpleasant taste?
❑	❑	13.	Do you get frequent canker sores (in the mouth)?
❑	❑	14.	Do you get frequent cold sores (on lip)?
❑	❑	15.	Do you have any white or red lesions in the mouth?
❑	❑	16.	Lumps or tumors in the mouth or neck?
❑	❑	17.	Are you aware of any loose or broken fillings?
❑	❑	18.	Have you had a difficult extraction?
❑	❑	19.	Sensitivity to sweets?
❑	❑	20.	Sensitivity to hot or cold liquids?
❑	❑	21.	Sensitivity to biting?
❑	❑	22.	Does food tend to become caught between your teeth?
❑	❑	23.	Do your gums often bleed while brushing?
❑	❑	24.	Have you noticed any loosening of teeth?
❑	❑	25.	Have you had an injury to your head, neck, or jaw?
		26.	Habits -
❑	❑		a. Clench or grind your teeth while awake or asleep?
❑	❑		b. Bite your lips or cheek frequently?
❑	❑		c. Bite your fingernails?
❑	❑		d. Mouth breathing?
❑	❑		e. Ice chewing?
❑	❑		f. Gum chewing?
❑	❑		g. Sucking on candies or cough drops?

Yes	No		
		27.	Problems of the jaw - Have you noticed:
❑	❑		a. clicking of the jaw?
❑	❑		b. Pain (joint, ear, side of face)?
❑	❑		c. Difficulty in opening or closing?
❑	❑		d. Difficulty in chewing?
❑	❑		e. Frequent headaches?
		28.	Have you had:
❑	❑		a. Orthodontic treatment (braces)?
❑	❑		b. Oral surgery?
❑	❑		c. Gum treatment?
❑	❑		d. Your bite adjusted?
❑	❑		e. Worn a bite plane or other appliance?
❑	❑		f. Wear a removable denture or partial?
			If so, when was it made? _____
❑	❑	29.	Has anyone in your family had gum treatment?
		30.	How often do you floss/day? _____
		31.	How often do you brush/day? _____
		32.	Circle what texture toothbrush you use: Soft Medium Hard
		33.	How many sodas a day do you drink? _____
		34.	How much coffee a day do you drink? _____
❑	❑	35.	Do you use tobacco?
			What kind _____
			How much _____
			For how long _____

Please explain if you answered "YES" to, or are uncertain about, any of the above items.

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Would you like to speak to the Doctor privately about anything? _____

I understand there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, and aspiration, pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature - Patient (or parent/guardian if patient is under age 18) Date