Name:______________________________

These things are important to me about my Dental Health:

(Please Circle One)

1. My mouth is
   A) very comfortable
   B) moderately comfortable
   C) uncomfortable

2. I (I am)
   A) think the appearance of my mouth is excellent
   B) satisfied with the appearance of my mouth.
   C) dissatisfied with the appearance of my mouth

3. I
   A) will do anything to keep my natural teeth
   B) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
   C) don't care whether I keep my teeth or not

4. I
   A) set goals for my oral health with a previous dentist
   B) want to set goals concerning my dental health
   C) never set goals concerning my dental health

5. I
   A) have always done the best that was recommended for my dental health
   B) have not done what dentists have recommended for my mouth
   C) rarely go, and don't care much about having my dental work completed.

6. I have
   A) put dentistry for myself and my family high on my priority list
   B) put dentistry for myself and my family low on my priority list
   C) it's on my list but hard to find.

7. I think my present state of dental health is
   A) excellent
   B) good
   C) poor

8. I aspire to a mouth with
   A) excellent health
   B) good health
   C) poor health

9. What is/are your primary concerns?
   ____
   ____
   ____
   ____
   ____

What could we do to make your visit more comfortable for you? ____

____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- ☐ Your last cleaning _____/_____
- ☐ Your last oral cancer screening ____/____
- ☐ Your last complete X-Rays _____/_____

If you could whiten your teeth for a cost anyone could afford, would you do it?

____

____

If you could change your teeth/smile, you would:

- ☐ Make them Brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Name of Previous Dentist:

____

City: ___________________ State: _______

Phone #: ______________________________