

## *Dental Information*

<p>Dentist's Name: _____</p> <p>City: _____</p> <p>How long has he / she been your dentist? _____</p> <p>Are you in dental discomfort today?                      Y    N</p> <p>Why did your dentist refer you? _____</p> <p>_____</p> <p>How long since your last cleaning? _____</p> <p>How often does your dentist / hygienist clean your teeth? _____</p> <p>Have you ever had root planing (deep cleaning) Y    N</p> <p>    If so, when? _____</p> <p>Are any of your teeth sensitive to:</p> <p>    Heat?    Cold?    Sweets?    Pressure?</p> <p>Are you missing any teeth?                                      Y    N</p> <p>    Why were your teeth removed?</p> <p>        Decay?    Periodontal Disease (Pyorrhea)?</p> <p>    Have the missing teeth been replaced?              Y    N</p> <p>Do you have any loose teeth?                                      Y    N</p> <p>Do your gums bleed when you floss or brush?              Y    N</p> <p>Do you have diabetes?    Y    N</p> <p>    Does anyone in your family have diabetes?              Y    N</p> <p>Did you ever smoke?    Y    N</p> <p>    If so, at what age did you start? _____</p> <p>    How much did / do you smoke? _____</p> <p>    When did you quit? _____</p>	<p>How often do you brush your teeth? _____</p> <p>Do you use any special tools to clean your teeth?</p> <table style="width: 100%;"><tr><td style="width: 50%;">Floss</td><td style="width: 50%;">How often? _____</td></tr><tr><td>Electric flosser</td><td>How often? _____</td></tr><tr><td>Rubber tip</td><td>How often? _____</td></tr><tr><td>Toothpick</td><td>How often? _____</td></tr><tr><td>Proxa-Brush</td><td>How often? _____</td></tr><tr><td>Water-Pick</td><td>How often? _____</td></tr><tr><td>End-Tuft toothbrush</td><td>How often? _____</td></tr></table> <p>Electric Toothbrush</p> <table style="width: 100%;"><tr><td style="width: 50%;">Braun-Oral-B</td><td style="width: 50%;">Interplak</td></tr><tr><td>Rota-Dent</td><td>Sonicare</td></tr></table> <p>Other</p> <p>Do you have any teeth that you cannot clean?</p> <p>    If so where? _____</p> <p>Do you clench or grind your teeth?                              Y    N</p> <p>    If so, have you been treated for it?                              Y    N</p> <p>Does your jaw make clicking or popping sounds? Y    N</p> <p>Does your jaw ever get sore or painful?                              Y    N</p> <p>Have you ever had braces to straighten teeth?              Y    N</p> <p>    If so when? _____</p> <p>Are you happy with your smile?                                      Y    N</p> <p>    If not, please describe: _____</p> <p>Are you fearful of dental treatment?                              Y    N</p> <p>    If so, please describe: _____</p>	Floss	How often? _____	Electric flosser	How often? _____	Rubber tip	How often? _____	Toothpick	How often? _____	Proxa-Brush	How often? _____	Water-Pick	How often? _____	End-Tuft toothbrush	How often? _____	Braun-Oral-B	Interplak	Rota-Dent	Sonicare
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