VALLEY DENTAL WORKS

Why have you come to the dentist today?_____

_____

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain\discomfort in your jaw joint (TMJ/TMC)? ❑ Yes ❑ No

Would you like information about anxiety free dentistry? ❑ Yes ❑ No

Do you clench? ❑ Yes ❑ No

Do you grind? ❑ Yes ❑ No

Do you have a nightguard? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

How many times a day do you floss? _____

How many times a day do you brush?_____

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do you do anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Do your gums bleed? ❑ Yes ❑ No

When?_____

Have you ever had gum disease? ❑ Yes ❑ No

Have you ever had root planing or a deep cleaning? ❑ Yes ❑ No

Are any teeth loose? ❑ Yes ❑ No

Does food get caught between your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else?

_____

_____

Do you still have your wisdom teeth? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

If yes, why?

Have you ever had orthodontic treatment? ❑ Yes ❑ No

Would you be interested in straightening your teeth with braces? ❑ Yes ❑ No

Rate your smile from 1-10 (10 = best)

1 2 3 4 5 6 7 8 9 10

What would you change about your teeth?

_____

_____

What would you change about your smile?

_____

_____

Have you been diagnosed with sleep apnea? ❑ Yes ❑ No

Do you use a CPAP? ❑ Yes ❑ No

Pre-screening for Sleep Disordered Breathing (SDB):

1. Do you snore? If so, how often do you snore? Has anyone said you stop breathing periodically at night?

_____

_____

2. Do you have daytime sleepiness? If so, how often? i.e. have you fallen asleep at work, driving, etc.

_____

_____

3. Do you have high blood pressure? ❑ Yes ❑ No

For Office Use Only

DENTAL HISTORY