Tampa Bay DENTAL ASSOCIATES

DENTAL HEALTH INFORMATION

Name: _____ **Date:** _____

We appreciate the confidence you have placed with us to provide Dental Care to you. All information on this form is necessary for our records and is strictly confidential. It will help us better serve you.

	Yes	No
Are you having any discomfort?	☐	☐
Any sensitivity to hot, cold, sweets, or chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐

Have you experienced any of the following problems?:

	Yes	No
Bleeding gums	☐	☐
Bad Breath	☐	☐
Soreness in jaw joint	☐	☐
Grinding teeth	☐	☐
Snoring	☐	☐

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like you dental health to be?
1 2 3 4 5 6 7 8 9 10

	Yes	No
Do you think your dental health effects your overall health?	☐	☐
Do you think it is important to have your teeth cleaned at least every six months?	☐	☐

	Yes	No
Is the brightness of your teeth important to you?	☐	☐
Do you smoke or use tobacco in any form?	☐	☐
Do you drink coffee or tea?	☐	☐

If I could change my smile I would make my teeth:

	Yes	No
Whiter	☐	☐
Straighter	☐	☐
Close space	☐	☐
Replace silver fillings with white tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Less gum showing	☐	☐
Replace old crowns or caps that don't match	☐	☐
Do you prefer to save your teeth?	☐	☐
If there were a way to whiten your teeth for a very reasonable investment, would you be interested?	☐	☐

Date of last cleaning: _____

When was last oral cancer exam? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____