

## DENTAL HISTORY

	Yes	No
1. Are your teeth sensitive to:		
Heat?	<input type="checkbox"/>	<input type="checkbox"/>
Cold?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Biting Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does food constantly get stuck between certain teeth in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you get frustrated because you always have something to be treated or repaired when you visit the dentist?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you dissatisfied with your teeth in any way?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, etc.	<input type="checkbox"/>	<input type="checkbox"/>
6. Do any of your fillings show when you smile?	<input type="checkbox"/>	<input type="checkbox"/>
7. If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>
9. How long have these teeth been missing?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have an unpleasant taste or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you frequently snack on sweets or chew gum between meals?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
14. Do you drink pop?	<input type="checkbox"/>	<input type="checkbox"/>
15. How often do you: Brush your teeth? _____ Floss your teeth? _____		
16. Do you want to learn to control dental disease and retain your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the fear of discomfort kept you from regular dental visits?	<input type="checkbox"/>	<input type="checkbox"/>
18. Would you like to know more about anxiety-free dentistry?	<input type="checkbox"/>	<input type="checkbox"/>
19. Are you deeply concerned about the finances required to return your mouth to excellent dental health?	<input type="checkbox"/>	<input type="checkbox"/>
20. When was your last dental appointment? _____		
21. What did you have done? _____		
22. How long since your last thorough examination with full mouth x-rays? _____		
23. Who was your previous dentist? _____		
24. What prompted you to seek dental care at this time? _____		
25. Is there anything else that we should know? _____ _____ _____ _____ _____		