

Dental Concerns

To you, what is the most important thing(s) to focus on during our first visit together?

About your goals and concerns Rank in order – 1 being most important.

I am most interested in the following benefits when selecting dental care:

_____ Comfort _____ Appearance _____ Peace of Mind _____ Good fit
_____ Function _____ Health _____ Durability Other _____

I consider the following costs when making decisions about my dental care:

_____ Money _____ Time _____ Personal Effort
_____ Physical Discomfort _____ Fear / Anxiety Other _____

What did you not like about your past dental treatments?

Treatment was uncomfortable Treated poorly Poor Results

Please tell us about any unpleasant / pleasant experiences you have had at the dentist:

What are you aware of in your mouth? Check all that apply

Teeth

Cavities Stained or discolored teeth
 Broken teeth, fillings or crowns Chipped or worn teeth
 Crooked, crowded or gap Pain or sensitivity
 Dental Implants Food packing when you eat
 Comfortable and able to chew well

Jaw joint (TMJ)

Headaches Vertigo / Dizziness Hot / Cold Sensitive Teeth
 Ear Congestion / Tinnitus Limited Opening TMJ Sounds – popping/clicking
 Clenching / Grinding Tender to Biting Unstable / Uncomfortable Bite
 Joint Pain Facial Pain Loose teeth
 History of Trauma to Head or Neck Numbness of Hands or Fingers
 Other Symptoms _____

Gums and bone

Bleeding gums Periodontal therapy or monitoring () Current () Past
 Sensitive gums Periodontist _____
 Bad breath Recession When was your last cleaning? (approx.) _____