Low Risk Moderate Risk High Risk Caries assessment

CONFIDENTIAL

Dental History

Patient Name: ____ Date _____________

Please print

Previous Dentist Name ____

Previous Dentist Address ____

____

Previous Dentist Phone # ____

Why did you leave your previous dentist? ___________________________________

____

(√) Check if you have or have had any problems with any of the following:

	Bad Breath		Chew on one side of the mouth
	Bleeding Gums		Tobacco Use
	Gums Swollen or tender		Chewing on foreign objects
	Sores, growths on lips or mouth		Fingernail Biting
	Biting, chewing on tongue		Thumb sucking
	Dry Mouth		Tongue thrusting
	Chewing		Pain on brushing teeth
	Swallowing		Loose or broken teeth
	Talking		Loose or broken fillings
	Prominent gag reflex		Sensitivity to hot
	Snoring		Sensitivity to cold
	Periodontal treatment		Sensitivity to sweets
	Orthodontic treatment		Sensitivity when biting
	Wisdom teeth extracted		Stained teeth
	Bite problems		Grinding or clenching teeth
	Missing teeth		Clicking or popping jaw
	Shifting position of teeth		Jaw pain or fatigue
	Burning sensation on tongue		Opening or closing jaw
			Pain around ear

Are you interested in teeth whitening? **Yes** **No** (please circle)

Are you interested in straighter teeth? **Yes** **No** (please circle)

How often do you brush? _____________ How often do you floss? _____________

Do you use fluoride toothpaste? **Yes** **No** (please circle)

Do you wear braces, orthodontic appliances, partials/dentures? **Yes** **No** (please circle)

Do you use chewing gum, mints, or other products that contain Xylitol? **Yes** **No** (please circle)

How often do you eat sugary foods? ____

How often do you have your teeth cleaned? _______ How often do you replace your toothbrush? ________

How would you improve you smile? ____

____

Dentist Initial ______________ Date_______