Maywell L Inong, DDS ~ General Dentistry

Patient's Name_____**Birth date**_____

Dental History

Name of Previous Dentist_____Phone_____
Address_____
Was the same dental insurance used? Yes / No
Date of last dental exam _____
Date of last x-rays_____ Circle Type of X-rays: Full Set / Check-up films (4 x-rays) / Panorex
Date of last dental cleaning _____ Circle Type of cleaning: Routine / Scaling and Root Planing
Date of last dental visit and treatment received_____
_____

Dental Condition: (circle all that apply)

Tooth Pain	Facial/Jaw Pain	Sensitivity	Decay	Loose Teeth	Bleeding Gums
Braces	Swelling/Lump	Difficulty Chewing	Clenching	Grinding	Gum Disease

Dental concerns/desires_____
_____
Rate your level of dental anxiety (0- none, 5-severe**)** **0 1 2 3 4 5**
What causes your dental anxiety? _____
Special care needed for dental treatment:

Nitrous Oxide (Laughing Gas)	Anxiety Medication	IV Sedation
Head needs to be elevated	Short appointments	Frequent Breaks

Personal Dental History

What prompted you to seek dental care at this time?

How healthy does your mouth feel?

Rate your dental health on a scale of 1-10 (1-poor, 10-excellent**)** **1 2 3 4 5 6 7 8 9 10**

What factors do you feel are responsible for the above score?

Share why or why not you are satisfied with your past dental care.

Describe your last unpleasant dental experience.

What are your long term goals for your teeth?

What do you wish or expect of me as your Dentist?

Smile Review

Are your front teeth straight and even in length? **Yes No Not Sure**
Are your front teeth all the same color? **Yes No Not Sure**
Are your teeth darker than you would like? **Yes No Not Sure**
Are any of your fillings a different color from your natural teeth? **Yes No Not Sure**
Do any unsightly restorations show in your back teeth when you smile broadly or laugh? **Yes No Not Sure**
Are the gums receding from the teeth? **Yes No Not Sure**
Are the gums swollen or puffy? **Yes No Not Sure**

If you could change your smile, what would you most like to change?