DENTAL HISTORY		
NameNicknameAge	Fair	Poor
PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [00000
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? 9. Have you ever noticed an unpleasant taste or odor in your mouth? 10. Is there anyone with a history of periodontal disease in your family? 11. Have you ever experienced gum recession? 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		000000
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? 18. Do you have grooves or notches on your teeth near the gum line? 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? 20. Do you frequently get food caught between any teeth?		0000000
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? 25. Are your teeth becoming more crooked, crowded, or overlapped? 26. Are your teeth developing spaces or becoming more loose? 27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? 28. Do you place your tongue between your teeth or close your teeth against your tongue? 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? 30. Do you dench your teeth in the daytime or make them sore? 31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? 32. Do you wear or have you ever worn a bite appliance? 33. SMILE CHARACTERISTICS	00000000	000000000000
33. Is there anything about the appearance of your teeth that you would like to change?		
34. Have you ever whitened (bleached) your teeth?		