# LAKE AVENUE DENTAL

Dental Information

How would you rate the condition of your mouth?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

I routinely see my dentist every:
☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not Routinely

Your current dental health is ☐ Good ☐ Fair ☐ Poor

How many times a week do you floss? ____________ A day do you brush? __________________

Date of most recent dental exam and dental x-rays:

What is your immediate concern?

If you could change anything about the appearance of your smile what would you like to change?

Check all that apply:

☐ Had complications from past dental treatment

☐ Had trouble getting numb

☐ Had any reactions to local anesthetic

☐ Had/have braces, orthodontic treatment

☐ Have you noticed any recent shifting/crowding of your teeth

☐ Have you ever whitened or bleached your teeth

- ☐ Have you experienced dry mouth

- ☐ Food gets trapped between any teeth
- ☐ You have difficulty chewing

- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth

- ☐ Have you experienced popping and/or clicking of your jaw joint

- ☐ You clench or grind your teeth

- ☐ You wear or have worn a bite appliance

- ☐ Gums bleed when brushing or flossing

- ☐ Treated for gum disease or were told you have lost bone around your teeth

- ☐ Noticed an unpleasant taste or odor in your mouth

- ☐ Experienced gum recession or tooth sensitivity

- ☐ Had any teeth become loose on their own (without injury)

- ☐ Experienced a burning sensation in your mouth

- ☐ You snore or wake up frequently during the night

- ☐ I gag easily

If any of the checked boxes need further explanation, please describe: