Dental Questionnaire for Sandra E Slater DDS

To answer yes please circle the words that apply to your experiences.

C/C	**Have You Noticed Teeth Sensitive to....?** Cold / Sweets / Pressure / Hot / Chewing / Other _________________________________ What is your main concern with your teeth, mouth, or smile? ____
Perio	**Do You Have …...?** Loose teeth / Bleeding gums / Bad Breath / Receding gums / Gum disease / Past gum treatment such as "Deep Cleaning" or "Gum Surgery" / Food trapping between teeth / Difficulty cleaning between teeth
Perio	Approx date of last cleaning ____ How often do you have cleanings? ____ Do you use tobacco ? No never / No I quit / Yes – how much? ______how long?_____ How often do you brush your teeth? ____________ Do you use a Manual tooth brush ? Yes / No Is it ... Hard / Medium / Soft Do you scrub your teeth hard? Yes / No Do you use an Electric tooth brush? Yes / No How often do you clean between your teeth? __________________ What do you use to clean between your teeth ? ______________________________
TMJ	**Do You Have Any of these Jaw Symptoms...?** Jaw pain / Clicking / Popping / Locking open or closed / Difficulty chewing Tired jaw muscles / Accident involving your jaw / Clinching, Gritting or Grinding teeth Uneven or Unstable bite when you close your teeth
Habits	**Do You Frequently Eat, Drink, or Suck on...?** Hard candy / Mints / Ice cream / Sticky candy / Sugar free sodas / Regular sodas Sugar free gum / Regular gum / Lemons / Pickles / Pickle juice / Other
Habits	**Do You Ever...?** Chew ice / Chew hard candy / Crack or chew hard nuts / Eat popcorn / Open packages with your teeth / Use your teeth as tools / Cracked, Chipped or Broken a tooth / Dry mouth
Cosmetic	**Are You Concerned About...?** Yellow or Dark teeth / Crooked teeth / Spots or Stains on teeth / Gaps between teeth Missing teeth / Have you ever whitened your teeth? Yes / No
Past	**In the Past have you had...?** Braces / Root canals / Wisdom teeth removed / Other teeth extracted / Night guard Tooth ache / Oral cancer / Dentures / Partials / Implants / Bridges Frequency of dental visits? every 6-12 months / sporadically / seldom / never Comprehensive dental exam? Yes / No Date: _________ Full series of xrays &/or Panorex xray? Yes / No Date: ___________

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care.

Patient's name Signature Date