OAKVILLE DENTAL CARE

We're glad you're here.

To better serve you, please take just a couple of minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- ○ Sensitivity (hot, cold or sweet)
- ○ Neckaches, earaches, neck pain
- ○ Teeth or fillings breaking
- ○ Grinding or clenching teeth
- ○ Bleeding, swollen or irritated gums
- ○ Loose, tipped or shifting teeth
- ○ Bad breath
- ○ Jaw Pain
- ○ Food impaction

How often do you brush?

How often do you floss?

Do you have or have you had any of the following?

- ○ Dentures
- ○ Partial dentures
- ○ Periodontal (gum) disease
- ○ Orthodontics (braces)

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Who was your previous dentist?

Name _____

City _____ State _____ _____

Phone _____

Why did you choose to seek another dentist? _____

_____

Do you smoke or use tobacco products?

○ Yes ○ No

If yes, how much per day, and for how long?

Do you have any fear or anxiety about going to the dentist? ○ **Yes** ○ **No**

Are you familiar with Nitrous Oxide Sedation (laughing gas)? ○ **Yes** ○ **No**

If you could change your smile, would you:

(please choose all that apply)

- ○ Make my teeth whiter
- ○ Make my teeth straighter
- ○ Close spaces between teeth
- ○ Replace black metal fillings with tooth-colored restorations.
- ○ Repair chipped teeth
- ○ Replace missing teeth
- ○ Replace old crowns that don't match
- ○ Receive a smile 'makeover'

On a scale of 1 to 5, with 5 being the highest rating:

(please circle the number that best applies)

How important to you is your dental health?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where would you like your dental health to rate?

1 2 3 4 5

What are the most important things to you about your smile and dental health?

What is the most important thing to you about your dental visit today?