Gilbert Road Dental Care **Dental History**

Why have you come to the dentist today? _____

Are you currently in pain or discomfort with your teeth and/or gums? ❑ Yes ❑ No

How would you describe the condition of your teeth and gums? ❑ Excellent ❑ Fair ❑ Poor

Previous Dentist: Last Visit Date:

Have you had orthodontics? ❑ Yes ❑ No If YES, at what age?

Do you have headaches? ❑ Yes ❑ No If YES, how often?

Gilbert Road Dental Care **Questionnaire**

❑ Y ❑ N Do you understand the correlation between dental plaque control ad the prevention of gum disease?

❑ Y ❑ N Do your gums ever bleed?

❑ Y ❑ N Have you ever been told you have gum disease?

❑ Y ❑ N Do you often feel your breath is not as fresh as it could be?

❑ Y ❑ N Do you grind or clench your teeth?

❑ Y ❑ N Have you ever had pain/discomfort in your jaw joint?

❑ Y ❑ N Do you snore or have you been told you do?

❑ Y ❑ N Do you sleep well? How long? _____

❑ Y ❑ N Would you like to have whiter teeth?

❑ Y ❑ N Would you like your teeth to be straighter?

❑ Y ❑ N Are you unhappy with any silver or discolored fillings?

❑ Y ❑ N Do you have crowns or bridges which are unattractive or unnatural looking?

❑ Y ❑ N Do you sometimes feel uncomfortable with the appearance of your smile?

❑ Y ❑ N Are your teeth crooked or crowded?

❑ Y ❑ N Do you think a more attractive smile would improve your personal and/or professional relationships?

❑ Y ❑ N Are you afraid or anxious to visit the dentist?

❑ Y ❑ N Do you wish that you could feel relaxed at your next dental appointment?

What level of dental care do you think your dental insurance company will cover? ❑ Excellent ❑ Fair ❑ Poor

What level of dental care would you like to have for yourself? ❑ Excellent ❑ Fair ❑ Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Agave Dental for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: Date: