Oral Health History and Patient Communication Preferences

Please answer the following:

NO YES Is it important for you to see the same Dentist and/or Hygienist for each visit?

NO YES Are you aware of any changes to your dental insurance plan? For the current plan year, or upcoming plan year?

NO YES Do you currently wear a CPAP machine for sleep apnea?

NO YES If you have a night guard (occlusal guard or bite splint), do you wear it consistently?

If no, please share why: ________________________

NO YES Have you been anxious about having dental treatment?

If yes, would you be comfortable sharing why? ________________________

Preferred Method of Communication:

Email: YES NO

If yes, preferred email address: ____________

Text Message: YES NO

Phone (please list / update):

____________ Home YES NO

____________ Cell YES NO

____________ Work YES NO

We encourage you to share any concerns you may have regarding your health, oral health, or smile:

Please check all that apply:

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food gets caught in between teeth
  If yes, where? ____________
- ☐ Bleeding while brushing teeth
- ☐ Unhappy with appearance of teeth
- ☐ Overbite / Underbite
- ☐ Uncomfortable bite
- ☐ Bad breath
- ☐ Old fillings or old crowns
- ☐ Difficulty chewing
  If yes, where? ____________
- ☐ Daytime sleepiness / drowsiness / dozing off
- ☐ Snoring

Have you ever been told that you stop breathing in your sleep? NO YES

Have you awakened with shortness of breath, gasping, or choking? NO YES

With whom may we discuss your dental care and visits?

- ☐ All Family
- ☐ Spouse:____________
- ☐ Do not share any of my information with anyone.
- ☐ Appointment date and times only
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Signature: ____________ Date: ____________

I have interest in the following:

- ☐ Teeth Whitening
- ☐ Oral Sleep Appliances
- ☐ Information regarding *Temporomandibular Joint Disorder*
- ☐ Veneers
- ☐ Dental implants
- ☐ Gingivitis and Periodontal Disease
- ☐ *Nitrous Oxide* (laughing gas) sedation?
- ☐ Orthodontic treatment
- ☐ At-home oral hygiene care
- ☐ Systemic links between oral health and overall health
- ☐ Oral hygiene care for infants and toddlers
- ☐ Oral health and X-rays during pregnancy
- ☐ Other: ____________

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Gathering the following information can be helpful for future treatment and insurance reimbursements (if applicable).

What are your goals in coming to our practice today? ____________

What is important to you in a dentist or dental practice? ____________

Have you had problems with prior dental treatment? Yes / No If yes, please explain: ____________

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Please rate your schedule flexibility based on scoring below:

1. Very little / no flexibility in my schedule. **2**. Some flexibility in my schedule / day and time dependent. **3**. Very flexible schedule

I am interested in learning how to take advantage of discounts toward dental treatment: Yes / No

Are you a full time student? YES / NO