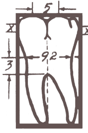
Dental Health



The
Dental Practice of
Robert W. Wheeler, D.D.S

"Combining the Art of Cosmetic Dentistry and Physiologic Occlusion"

Reason for today's visit____

Are you currently experiencing any discomfort? ☐ Yes ☐ No

If so, please describe ____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe ____

Have you ever had trouble with a previous dental treatment? ☐Yes ☐No

If so, please describe ____

Level of anxiety about seeing dentists: (least) 1 2 3 4 5 (most)

Dental History

Date of last dental exam_____________ Date of last cleaning _____________ Date of last full mouth X-rays_____________

Procedure(s) done at last dental visit ____

Previous dentist's name ______________________City _____________State _____Phone (   )________-____________

Why are you changing dentists?____

How often do you have dental examinations? ______________ How often do you brush your teeth? _________________

How often do you floss? ____________________________What type of bristles do you use? ☐ Hard ☐Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.)____________________________________

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Do you have, or have you ever had, any of the following? Please check all that apply

Mouth	Teeth
☐ Bleeding /sore gums	☐ Loose teeth
☐ Unpleasant taste/bad breath	☐ Sensitivity to heat
☐ Frequent blisters	☐ Sensitivity to cold
☐ Swelling/lumps in mouth	☐ Sensitvity to sweets
☐ Braces	☐ Sensitivity to biting
☐ Biting of cheeks/lips	☐ Food impaction
☐ Clicking/popping jaw	☐ Clenching/grinding If so, when?_______________
☐ Difficulty opening or closing jaw	☐ Shifting or change in bite

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Your Smile

Do you like the appearance of you teeth/smile? ☐ Yes ☐ No

If not explain____

Are your teeth all in alignment (Straight)? ☐ Yes ☐ No

If not explain____

Do you have spaces or chips you don't like? ☐ Yes ☐ No

If yes explain____

Do you like the color of you teeth? ☐ Yes ☐ No

If not explain____

Do you like the shape of your teeth? ☐ Yes ☐ No

If not explain____

Are there any old fillings or dental work you don't like looking at? ☐ Yes ☐ No

If yes explain____

How would you like your teeth to look?

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Robert W. Wheeler, D.D.S.