DR. LOUIS SIMMONS, DR. MICHAEL SIMMONS & DR. GERALD SIMMONS

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Answers to the following questions are for our records only. They will be considered confidential and will become part of your permanent dental record.

1. When is your next dental appointment? _____

2. How long has it been since you had:

	DATE	DATE	DATE	DATE
a) your last dental exam				
b) your dental hygiene care appointment				
c) radiographs of your entire mouth				
d) radiographs of part of your mouth				

Please answer the questions by checking either Yes or No, or write in your response. (If you are uncertain about the question, leave it unanswered.)

3. Have you ever had canker sores or cold sores? ❑ No ❑ Yes
4. Do you have lumps or sores (lesions) in your mouth now? ❑ No ❑ Yes
5. Have you ever been treated for gum or periodontal disease? ❑ No ❑ Yes When? _____
   How was the infection treated? _____
6. Do your teeth ever feel sore when you bite on them? ❑ No ❑ Yes
7. Do hot, cold, or sweet beverages cause discomfort or pain in your mouth? ❑ No ❑ Yes
8. What do you eat between meals? _____
9. How often do you eat or drink sugar-containing products? _____
10. How often do you brush your teeth? _____
11. What type of brush do you use? _____
12. Do you use dental floss? ❑ No ❑ Yes How often? _____
13. Do your gums bleed? ❑ No ❑ Yes When? _____
14. Do you use other oral hygiene aids? ❑ No ❑ Yes What type? _____
15. Do you:
    a) clench your teeth ❑ No ❑ Yes
    b) grind your teeth ❑ No ❑ Yes
    c) bite foreign objects ❑ No ❑ Yes
    d) bite your nails ❑ No ❑ Yes
    e) have difficulty swallowing ❑ No ❑ Yes
    f) breath through your mouth ❑ No ❑ Yes
    g) have other oral habits ❑ No ❑ Yes
    h) smoke or use any other tobacco products ❑ No ❑ Yes
       If yes, what type? _____
       How frequently? _____
16. Do you use any of the following:
    a) fluoridated water ❑ No ❑ Yes
    b) fluoride toothpaste ❑ No ❑ Yes
    c) fluoride/rinse gel ❑ No ❑ Yes
    d) mouth rinses ❑ No ❑ Yes
    e) tartar-control toothpaste ❑ No ❑ Yes
    f) sensitivity toothpaste ❑ No ❑ Yes
    g) other _____
17. Have you ever had:
    a) orthodontic treatment (braces) ❑ No ❑ Yes
    b) endodontic treatment (root canal) ❑ No ❑ Yes
    c) extractions ❑ No ❑ Yes
    d) jaw surgery ❑ No ❑ Yes
    e) dental implants ❑ No ❑ Yes
    f) TMJ treatments ❑ No ❑ Yes
18. Are you nervous about dental treatment? ❑ No ❑ Yes
19. What value do you place on your teeth? (0-Not at All - 10-Very Highly) 0 1 2 3 4 5 6 7 8 9 10
20. Who referred you to our clinic? _____
21. Have you ever had any trouble associated with previous dental treatment (e.g., dizziness, fainting, or reaction to novocaine)? ❑ No ❑ Yes
22. Have you ever had an unpleasant experience in the dental office? ❑ No ❑ Yes
23. What are your primary dental concerns now? _____

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