

DENTAL EVALUATION

Elena C. Puig, DMD, PA, 1600 E. Hillcrest Street, Orlando, FL 32803



DATE: _____

PATIENT'S NAME: _____

What is the main reason for your visit today? _____

Are you currently having pain? _____ Do you require antibiotics before dental treatment? Yes ___ No ___

Is there anything about your smile that you don't like? _____

Do you like the appearance of your teeth? _____

Are your teeth all in alignment (straight)? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing, biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you like to change anything about the appearance of your smile? Yes _____ No _____

If so, what _____

If we could enhance your smile by giving you whiter, more aligned teeth would you be interested? Yes ___ No ___

If you are nervous would you like to have your dentistry done with nitrous oxide (laughing gas)? Yes ___ No ___

Is there anything about your mouth that concerns you now? Yes _____ No _____

If yes, explain _____

How long has it been since you have seen a dentist and for what reason? _____

Were radiographs taken at this last visit? yes _____ no _____

Have you ever had orthodontic treatment? yes _____ no _____

Do you use dental floss, toothpicks? yes _____ no _____

Have you ever had wisdom teeth removed? yes _____ no _____

Do your gums ever bleed? yes _____ no _____

Are any of your teeth loose? yes _____ no _____

Do you have any swelling, sores or blisters in your mouth? yes _____ no _____

Have you ever been told that you have gum disease? yes _____ no _____

Have you ever visited a periodontist (Gum specialist)? yes _____ no _____

Do you smoke? yes _____ no _____

Do you feel you have unpleasant breath at times? yes _____ no _____

Are you interested in using sedatives while dental treatment is being performed? yes _____ no _____

How would you rate your dental health on a scale of 1—10 with 10 being the best? _____

What are your hobbies/interests/pastimes other than work? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant?

IS THERE ANYTHING THAT WE CAN DO TO MAKE YOUR DENTAL VISITS MORE COMFORTABLE? _____