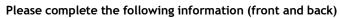
Welcome to Tooth Booth





Pat	ent NameNicknameAge				
Add	lress: Cell/home#: Email:				
Em	ergency contact: Phone#: Relation:				
Ref	erred byHow would you rate the condition of your mouth? DExcellent DGood D	JFair □ F	oor		
	vious DentistHow long have you been a patient?Months/Y				
Dat	e of most recent dental exam/treatment				
	ne of PhysicianPhone#:				
I ro	utinely see my dentist every 3 mo. 4 mo. 6 mo. 12 mo. Not routinely				
WH	AT IS YOUR IMMEDIATE CONCERN?				
PLE	EASE ANSWER YES OR NO TO THE FOLLOWING:				
PER	SONAL HISTORY O CO	YES	NO		
1.	Are you fearful of dental treatment? How fearful on a scale of 1(least)to10(most)[]				
2. 3.	Have you had an unfavorable dental experience? Have you ever had complications from past dental treatment?	\mathcal{C}	Н		
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	ŏ	ŏ		
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	Ō	Ō		
6.	Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?				
GU	M AND BONE	YES	NO		
7.	Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?				
8.	Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	Ö	\bigcirc		
9.	Have you ever noticed an unpleasant taste, odorin your mouth, or swollen and puffy gums?	Ю	Ю		
10.	Is there anyone with a history of periodontal disease in your family? Have your every experienced gum recession, or can you see more of the roots of your teeth?				
11. 12.	Have you ever experienced gum recession, or can you see more of the roots of your teeth? Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?		\mathcal{C}		
	Have you experienced a burning, painful sensation, or metallic taste in your mouth?	ŏ	Ö		
TO	OTH STRUCTURE O	YES	NO		
14.	Have you had any cavities within the past 3 years?				
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing or chewing any food?	\Box			
	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	Ö	\bigcirc		
	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	$\bigcup_{i=1}^{n}$	\Box		
	Do you have grooves or not chew on your teeth near the gum line?				
19. 20.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	\mathcal{C}	\sim		
		YES	NO		
	E AND JAW JOINT	1123	NO		
21. 22.	Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? Do you feel like you need to pull your lower jaw back, when you try to bite your back teeth together?		$\tilde{\Box}$		
23.	Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	$\tilde{\Box}$	Ŏ		
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	Ŏ	Ō		
25.	Are your teeth becoming more crooked, crowded, or overlapped?				
26.	Are your teeth developing spaces or becoming more loose?				
27.	Are your teeth developing spaces or becoming more loose?		\mathcal{C}		
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	\sim	\sim		
29.	Do you chewie, bite your nails, use your teeth to hold objects, or have any other oral habits?		ŏ		
30.	Do you clench or grind your teeth together in the daytime/nighttime or ever make them sore?	\mathcal{L}	Ō		
31. 32.	Do you wear or have you ever worn a bite appliance?	ŏ			
SM	ILE CHARACTERISTICS	YES	NO		
	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces ,size ,shape)				

	MEDICA	ΔI	ш	ICT	ORV					
		_								
	nat is your estimate of your general health?		Exce	ellen [.]	t 🗌 Good 🗍 Fair 📗 Poor					
DC	YOU HAVE or HAVE YOU EVER HAD:	YES	NO			YES	NC			
1. 2.	hospitalization for illness or injury an allergic or bad reaction to any of the following: O aspirin, ibuprofen, acetaminophen, codeine O penicillin O erythromycin O tetracycline O sulfa O local anesthetic O fluoride O chlorhexidine (CHX) O lodine O metals (nickel, gold, silver, O latex O nuts O fruit O milk O red dye			27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates)					
3. 4. 5. 6. 7. 8. 9.	O other heart problems, or cardiac stent with in the last six months history of infective endocarditis artificial heart valve, repaired heart defect (PFO) pacemaker or implantable defibrillator orthopedic or soft tissue implant (e.g., joint replacement) heart murmur, rheumatic or scarlet fever high or low blood pressure a stroke (taking blood thinners)		00000000	39. 40. 41. 42. 43. 44. 45.	HIV/AIDS		00000000000000000			
12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25.	anemia or other blood disorder)0000000000000000000000000000000000000			0000000000000	47. 48. 49. 50. 51. 52. 53. 55. 56. 57. 58.	presentlybeing treated for any other illness awareofachangeinyourhealthinthelast24hours (e.g., fever, chills, new cough, or diarrhea) taking medication forweight management taking dietary supplements, vitamins, and/or probiotics often exhausted or fatigued experiencing frequent headaches or chronic pain a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) considered a touchy/sensitive person often unhappy or depressed taking birth control pills currently pregnant diagnosed with a prostate disorder ent delay, or other treatment that may possibly affect		00 0000 00000
denta 	I medications, supplements, vitamins, and/or probiotics taken Drug Purpose	ken w	vithin t			e we day wise r NO	<u>s</u>			