Indy Dental Group®
Comprehensive, Cosmetic & Family Dentistry
www.indydentalgroup.com

DENTAL SCREENING

Patient Name: _____**Date of Birth:** _____

Reason for today's visit:_____

Date of last dental care/cleaning: _____**Date of last x-rays**: _____

Former Dentist: _____

- ☐ **Yes** ☐ **No** Are you nervous about dental treatment/cleanings?
- ☐ **Yes** ☐ **No** Do you brush your teeth? How often_____
- ☐ **Yes** ☐ **No** Do You floss? How often_____
- ☐ **Yes** ☐ **No** Do your gums bleed when you brush or floss?
- ☐ **Yes** ☐ **No** Are your teeth sensitive to hot or cold foods/liquids?
- ☐ **Yes** ☐ **No** Sensitivity when biting?
- ☐ **Yes** ☐ **No** Sensitivity to sweets?
- ☐ **Yes** ☐ **No** Loose or broken teeth?
- ☐ **Yes** ☐ **No** Sores in mouth or lips?
- ☐ **Yes** ☐ **No** History of oral cancer?
- ☐ **Yes** ☐ **No** Do you snore or sleep with your mouth open?
- ☐ **Yes** ☐ **No** Have you ever had any type of trauma/injury to your mouth, jaw or face? If yes, please describe: _____
- ☐ **Yes** ☐ **No** Have you experienced any of the following problems with your jaw? (Circle ALL that apply): clicking, popping, difficulty in opening/closing, pain with chewing, headaches, grinding, clenching
- ☐ **Yes** ☐ **No** Have you ever had orthodontic treatment(braces)? If so, do you wear a retainer? How often? _____
- ☐ **Yes** ☐ **No** Do you wear dentures or partials? How old are they? _____
- ☐ **Yes** ☐ **No** Do you have concerns about bad breath/odor?
- ☐ **Yes** ☐ **No** Are you pleased with the appearance of your teeth when you smile? What would you change? _____
- ☐ **Yes** ☐ **No** Are you pleased with the color of your teeth?
- ☐ **Yes** ☐ **No** Is there any dental work you are not happy with? _____