R. CARSON KIGHT, DMD
DISTINCTIVE DENTISTRY

Dental Health Information

Thank you for providing us with important information that will help us serve you better.

Are you having any discomfort?	Yes	No
Any sensitivity to hot, cold, sweets or chewing?	Yes	No
Does dental treatment make you nervous?	Yes	No
Is the brightness of your teeth important to you?	Yes	No
Do you smoke or use tobacco in any form?	Yes	No

Have you experienced any of the following problems?

Bleeding gums	Yes	No
Bad breath	Yes	No
Soreness in jaw joint	Yes	No
Grinding your teeth	Yes	No
Snoring	Yes	No

If you could change anything about your teeth—would you make them?

Whiter	Yes	No	Replace missing teeth	Yes	No
Replace old crowns or caps	Yes	No	Close spaces (gaps)	Yes	No
Replace metal (black) fillings	Yes	No	Have less gum showing	Yes	No
Repair chipped teeth	Yes	No	Straighter teeth	Yes	No
Be able to chew better	Yes	No			

Do you…?

think your dental health affects your overall health?	Yes	No
think it is important to have your teeth cleaned? At least ever 6 months?	Yes	No
prefer to save your teeth?	Yes	No
have a difficult time listening and understanding while you are in a dental chair?	Yes	No

Would whitening your teeth (for a reasonable investment) interest you?	Yes	No
Has a dentist or hygienist ever made you feel bad about your teeth or home care?	Yes	No

When was the last time you had an oral cancer exam? _____
Date of your last cleaning: _____
What is the most important thing to you about your dental visit today? _____

On a scale of 1 to 10, 10 being the highest
How important is your dental health? _____
Where would you rate your current dental health? _____