Dental Evaluation

Name:……. Date:……..

The information in this Evaluation sheet will assist us during your clinical consultation so that we can make a thorough diagnosis of your dental health.

You will have an opportunity to discuss your concerns and aspirations during your visit with us.

If you are new to this practice, why have you decided to leave your previous dental practice?

_____

Please tick the appropriate boxes below.

- ☐ My mouth is very comfortable.
- ☐ My mouth is moderately comfortable.
- ☐ My mouth is uncomfortable.

- ☐ I think my present state of dental health is excellent.
- ☐ I think my present state of dental health is good.
- ☐ I think my present state of dental health is poor.
- ☐ I have hole/s in my teeth.
- ☐ My teeth are painful and sensitive to hot, cold, or sweet foods.
- ☐ I have teeth that keep breaking.
- ☐ I have lost teeth that could have been saved with earlier intervention.

- ☐ I put dental care high on my list for myself.
- ☐ I want to keep my teeth but only within a certain budget of time and money.
- ☐ I will do whatever I must to keep my teeth.

- ☐ I have always done what was recommended to me.
- ☐ I have not done that was recommended to me.
- ☐ I have not had dentistry recommended to me.

- ☐ I am worried that I may have bad breath.
- ☐ My gums bleed when I brush.
- ☐ My gums are red and swollen.
- ☐ I have an unpleasant taste in my mouth.
- ☐ My teeth feel looser than they used to.
- ☐ My teeth have moved from their original position with time.
- ☐ My parents lost their teeth due to gum disease.

- ☐ My partner / parents / grandparents always had problems with their teeth.

I judge / value my dental health on the basis of:

☐ Cost ☐ Quality (Please only tick 1 box)

- ☐ I am aware of clenching my teeth during the day.
- ☐ I have more than one bite.
- ☐ I sometimes sleep restlessly at night.
- ☐ I have been made aware of clenching / grinding my teeth during the night.
- ☐ My teeth and jaw feel tired when I wake up.
- ☐ I suffer from chronic headaches or neck pains or shoulder pains.
- ☐ I have had pain in my jaw joint or the side of the face around the ear.
- ☐ I have difficulties or limitations in opening my mouth.
- ☐ My jaw joints click when I open & close my mouth.
- ☐ I chew on just one side of my mouth.
- ☐ I have had past dental work done that has stopped me from biting together normally.
- ☐ I have painful, sensitive teeth.
- ☐ I frequently get toothaches.
- ☐ I have problems chewing hard types of food (chewing gum / rolls)
- ☐ My teeth are slowly wearing down with time.
- ☐ I have had my teeth straightened with a brace.

Hold a mirror at least a foot from your face, preferably under natural daylight, and take a careful look at your smile and teeth before answering the following:

- ☐ I am satisfied with the appearance of my smile.
- ☐ I would like to change my smile.
- ☐ I am not happy with the colour of my teeth and would like them to be brighter.
- ☐ I have old crowns that do not match my other teeth.
- ☐ I have crowded teeth that I would like to straighten.
- ☐ I have spaces between my teeth that I don't like.
- ☐ I have missing teeth that I would like to replace.
- ☐ I have old stained & unsightly fillings that I don't like looking at and would like to replace with latest tooth-coloured fillings.
- ☐ My family have passed comments on my teeth.
- ☐ I have become increasingly conscious about my smile when I see myself in a mirror or photos.
- ☐ My smile is important in my life and career.

Please Handle Me With Care

Please tick the box next to the statement that concerns you.

- ☐ I gag easily
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what you will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain and anxiety relief is a top priority to me.
  My preferred method of pain relief is:
  - ☐ Local Anaesthetic
  - ☐ Oral Sedation
  - ☐ Intravenous Sedation
- ☐ I don't like injections, or I've had a bad reaction to injections.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of the instruments that make the picking noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.

Payment preference

Please tick one box.

- ☐ Cash or personal cheque prior to treatment
- ☐ Visa, Mastercard or Maestro prior to treatment
- ☐ I wish to budget and personalise my financial arrangements.

Obstacles that you see to excellent dental health for yourself.

If you select more than one of the following please number them in order of significance with No.1 being that which is most significant for you at this time.

- ☐ Time away from work or other obligations.
- ☐ Fear of pain, surgery or injections.
- ☐ Fear because of past dental experiences.
- ☐ Investment in the treatment
- ☐ Other _____
- ☐ No obstacles.

Other comments _____

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