DENTAL HEALTH RECORD

Dr. Benjamin S. Fiss, D.D.S. LTD.

Name ____

Date ____

Reason for visit? ____________________________________

When was your last dental visit? ______________________________

Do you smoke? ___________ If so, how much a day? ______________

How often do you brush your teeth? ___________________________

How often do you floss? ___________________________________

Do your gums bleed while flossing? ___________________________

Do your gums feel tender or swollen? __________________________

Have you ever had instruction in the care of your gums? ______________

Are you familiar with the term "preventive dentistry"? _________________

Are your teeth sensitive when they come in contact with:

a.) Hot foods or liquids? _________ If so, where? _________________

b.) Cold foods or liquids? ________ If so, where? _________________

c.) Sweets? __________________ If so, where? _________________

Are you confident smiling in front of people? _______________________

Are you satisfied with the appearance of your teeth? (color, shape, etc…)

____

Are there any unsightly fillings that you would like to have replaced?

____

Do you feel that your existing dental work is in good condition?

____

Do you clench or grind your teeth while sleeping or during the day?

____

Do you have / wear a Night Guard presently? ________________________________