Michael J. Nelson, D.D.S.
Small town dentistry in a big city

MEDICAL / DENTAL HEALTH UPDATE

DENTAL INFORMATION

Do you drink sugar pop or diet pop? _____

How much soda pop do you drink each week? _____

How often do you floss? _____

How often do you brush? _____

Date of last teeth cleaning. _____

Date of last dental treatment. _____

Y	N	
❑	❑	Have you ever had an upsetting experience in the dental office?
❑	❑	Do you like your smile?
❑	❑	Do you like the color of your teeth?
❑	❑	Is it important for you to keep your teeth?
❑	❑	Are you dissatisfied with the function of your teeth?
❑	❑	Is there anything about having dental treatment that bothers you?
❑	❑	Does food tend to become caught between your teeth?
❑	❑	Do your gums bleed while brushing or flossing?
❑	❑	Have you noticed any loosening of teeth?
❑	❑	have you had an injury to your head, neck, or jaw?
❑	❑	Do you have dryness in your mouth?
❑	❑	Are you having dental pain at this time?
❑	❑	Do you use fluoride toothpaste?

Y	N	
		Have you had:
❑	❑	a. Orthodontic treatment (braces)?
❑	❑	b. Oral surgery?
❑	❑	c. Gum treatment?
❑	❑	d. Your bite adjusted?
		Do you:
❑	❑	a. Wear an occlusal appliance / night guard?
❑	❑	b. Clench your teeth?
		Have you noticed:
❑	❑	a. Clicking of the jaw?
❑	❑	b. Jaw pain (Joint, ear, side of face)?
❑	❑	c. Difficulty in opening or closing?
❑	❑	d. Difficulty in chewing?
❑	❑	e. Frequent headaches, especially in morning?

Please explain if you answered “YES” to, or are uncertain about, any of the above items.

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is complete and correct.

Signature: _____ Date: _____

(If Under 18, Parent or Guardian Signature Required)