MURPHY DENTAL GROUP

SELF EVALUATION OF ORAL HEALTH

Name_____

- How were you referred to our practice? _____
- What is your immediate concern for your dental care? _____
- Do you like the appearance of your teeth or your smile? ____YES____NO

  If not, why not? _____
- Do you like the color of your teeth? ___YES ___NO

  If not, why not? _____
- Do you have spaces between your teeth that bother you? ____YES ___NO

  If yes, any comments? _____
- If teeth are crooked or crowded, does that bother you? ____YES ____ NO

  If yes, any comments? _____
- Do you have old filings or dental work that is unsightly? ____YES _____NO

  If yes, any comments? _____
- What if anything would you like to change about your smile? _____
- Do you show too much gum when you smile? _____YES _____NO

  If yes, does this bother you? _____
- What is your long term concerns for your dental care?_____

  _____
- If your smile were improved, would you feel more confident?

  _____

- Is there anything that concerns you about cosmetic treatment of the teeth or gums? _____YES _____NO
- How many times have you had your teeth cleaned in the past five years?
- Have you ever had periodontal care _____YES _____NO
- Orthodontic care ____YES _____NO

- Have you ever had experienced any of the following?

  ___bleeding or swelling gums ___pus around the teeth ___bad breath

  ___receding gums ___loose teeth ___food packing between teeth

  ___spaces between teeth ___drifting teeth ___high or rough filings.

- Do you grind your teeth or have TMJ problems? ___YES ___NO
- Do you have chronic headaches? ___YES ___NO
- Does your jaw click or pop when chewing or talking? ___YES ___NO
- Do you wear a night guard? ___YES ___NO
- Overall, how do you feel about your smile, and how would you like your teeth to look?

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Cosmetic, Implant and General Dentistry