Ryan P. Estes D.M.D. Allison K. Marlow D.D.S

ryanestesdmd@gmail.com

8136 Mall Road • Florence, KY 41042

(859)371-6543

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Dentist name and how long you have been a patient there:

____

____

Date of most recent dental visit _____________

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern/ How did your dentist explain why you are seeing us?

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Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ______________

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Notes:

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Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Notes:

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Bite and Jaw Joint, Check all that apply:

- [ ] You have problems with your jaw joint
- [ ] You have any problems chewing
- [ ] Your teeth changed in the last 5 years, become shorter, thinner, or worn
- [ ] Your teeth crowding or developing spaces
- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench you teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance

Notes:

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Tooth structure, Check all that apply:

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing food
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
- [ ] Any teeth with grooves, notches, chips, a cracked filling or pain
- [ ] Food gets caught between any teeth

Notes:

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Gum and Bone, Check all that apply:

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for bone loss
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth

Notes:

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If any of the checked boxes need further explanation, please describe:

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Response Date: ____/____/________