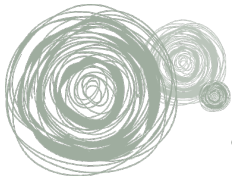

Matthew S.M. Yun
Steven R. Powell
GENERAL DENTISTRY

Name: _____ Date: _____

Check those that apply
My mouth is:

- ◯ Very comfortable
- ◯ Moderately comfortable
- ◯ Uncomfortable

- ◯ I think the appearance of my mouth is excellent
- ◯ I am satisfied with the appearance of my mouth
- ◯ I am dissatisfied with the appearance of my mouth

- ◯ I will do anything to keep my natural teeth
- ◯ I want to keep my teeth, but time and/or money are factors
- ◯ I don't care whether or not I keep my teeth

- ◯ I have set my oral health goals with a previous dentist
- ◯ I want to set my goals concerning my dental health
- ◯ I never have set goals concerning my dental health

- ◯ I have always done the best that was recommended for my dental health
- ◯ I have not done what dentists have recommended for my mouth
- ◯ I rarely go to a dentist and don't care much about having my dental work completed

- ◯ I put dentistry for myself and my family high on my priority list
- ◯ I put dentistry for myself and my family low on my priority list
- ◯ I put dentistry on my list, but it is hard to find the time

I think my present dental heath is: ◯ Excellent ◯ Good ◯ Poor

I aspire a mouth with: ◯ Excellent health ◯ Good health ◯ Poor health

How often do you see a dentist? _____

Are you having any dental problems that require immediate attention? _____

Do you have any tooth discomfort? ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing

How often do you brush your teeth? _____ Floss? _____

How do you feel about the appearance of your smile? _____

Have you ever had cosmetic dentistry done to improve your appearance? ◯ Yes ◯ No

If yes, are you pleased with the results? _____

Do you snore, or have you been told that you snore? _____

Have you had a sleep study? _____ When? _____

Have you been diagnosed with Sleep Apnea? _____

	YES	NO
Do your gums bleed while cleaning?	◯	◯
Do your gums ever feel tender or swollen?	◯	◯
Have you had treatment for gum disease?	◯	◯
Do you clench or grind your teeth?	◯	◯
Do your jaws ever feel tired or ache?	◯	◯
Do your jaws ever click or pop?	◯	◯
Can you chew on both sides of your mouth?	◯	◯
Do you have frequent headaches?	◯	◯
Do you have frequent earaches?	◯	◯
Have you ever had orthodontic treatment?	◯	◯
Do you lose or break fillings?	◯	◯
Have you had many cavities?	◯	◯
Do you have any loose teeth?	◯	◯
Do you have any cracked or broken teeth?	◯	◯
Do you have any food traps?	◯	◯
Do you have any missing teeth?	◯	◯
Have your missing teeth been replaced?	◯	◯

If so,

◯ Fixed bridge ◯ Removable partial ◯ Full denture ◯ Implant

If so,

Are you comfortable with the replacement? ◯Yes ◯No

PHYSICANS NAME _____

PREVIOUS DENTIST NAME _____

DATE OF YOUR LAST DENTAL VISIT _____

Whom may we thank for referring you to your practice? _____

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. Dr. Yun and his staff are dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals to dental health.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical/dental status.

Patient's Signature _____ Date _____
(if child, parent or guardian)