

Gerri Robin, DMD, FAGD

Pre-Clinical Interview

Name _____ Date _____

Please rate your dental health from 0-10 _____

Do you have any problems at the present time? _____

Do you have any pain in any part of the mouth or in any tooth while biting or chewing? If so, Where? _____

Do you have any pain in your teeth because of heat, cold or sweets? If so, Where? _____

Does food catch between your teeth? If so, Where? _____

Do your gums bleed between your teeth? If so, Where? _____

Do you chew on both sides of your mouth? If not, Why? _____

Do you ever have headaches? A stiff neck? _____

Are you in the habit of biting your nails or any other hand objects (pens, cigars, pipes, tags from stores)? _____

Do you clench your teeth during the day? _____

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Have you been made aware of grinding your teeth during the night?

Do you go to the dentist regularly? When was the last time you had a complete set of x-rays? _____

How often do you clean your teeth? _____

Do you use dental floss? How Often? _____

How often do you have your teeth cleaned? _____

Have you gums ever been treated? _____

Do you know extensive destruction of the bone under the gum can take place before the patient is aware of it? _____

Have you ever had any teeth removed? If so, was a general or local anesthetic used? Which do you personally prefer? _____

How long have these teeth been missing? _____

Do you need Novocain for dental treatment?

Normal Amount _____ A Lot _____ No Epinephrine _____

Do you need nitrous oxide for treatment? _____

Do you have pain or noise when you open or close your jaw? _____

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How are, or were, your parent's teeth? _____

Has any dentist ever given you a master plan of treatment to help you keep your teeth? Would you like one? _____

Have you ever had Orthodontic (Braces) Treatment? If so, when?

Have you ever had Periodontal (Gum) Treatment? If so, When?

Do your gums bleeding while flossing or brushing? _____

Do you gag easily? _____

Is there anything you would like to change about the appearance of your teeth?

_____ Color, too yellow, too gray

_____ Shape, too big, too small, crowding

_____ Spaces (Diastemas)

_____ Protruding (Buck)

_____ Too Long, Too Short

Other _____

If we show you a method that takes **only minutes a day to prevent cavities**, gum problems, and can help you save your teeth, would you be interested? Has any dentist ever given you a master plan of treatment to help keep your teeth?

Would you like one? _____.