Shelly McAvoy, DMD

8460 Cooper Creek Blvd., Ste. 103
University Park, Florida 34201

COOPER CREEK DENTAL
Where you're more than a patient

Ann Mooney, DMD

Phone: 941-366-1010
www.coopercreekdental.com

DENTAL HISTORY

Name _____ Date of Birth _____

WHEN WAS YOUR LAST: Dental Exam?_____ Cleaning?_____

Dental X-Rays?_____ Oral Cancer Screening? _____

Why did you leave your previous dentist?_____

Name of Previous Dentist _____ City _____State _____

SENSITIVITY/DISCOMFORT OF YOUR TEETH:

Are you having any PAIN/DISCOMFORT? _____

Where? UR LR UL LL

Rate your current pain from 1 - 10, with 10 being most painful:

1 2 3 4 5 6 7 8 9 10

	Yes	No
Do you have CHIPPED, BROKEN, OR CRACKED Teeth?	❑	❑
Do you have any SENSITIVITY to:		
HOT?	❑	❑
COLD?	❑	❑
SWEETS?	❑	❑
Are you anxious/nervous upon coming to the dentist office?	❑	❑
Do you use Sensitive Toothpaste?	❑	❑
Do you use Home Flouride?	❑	❑
Does your mouth get DRY?	❑	❑

HOME CARE:

Do you use an Electric Toothbrush?	❑	❑
What Brand?_____		
Do you use a manual tootbrush?	❑	❑
Do you use soft, medium, or hard bristles?_____		
How often do you brush?_____ times per day		
How often do you floss? _____ times per day		
Are you concerned about bad breath?	❑	❑

HABITS:

Do you smoke or use chewing tobacco?	❑	❑
How much? _____ For how long? _____		
Do you drink alcohol?	❑	❑
How much? _____ # of drinks per week_____		

	Yes	No
CONTACT/NON-CONTACT SPORTS:		
Are you involved?	❑	❑
List sport(s)? _____		
Have you ever worn a mouthguard or Athletic guard?	❑	❑
Have you ever worn Sports Enhancement Appliances?	❑	❑
TMJ:		
Do you have Headaches, Earaches, or Neck Pain?	❑	❑
Do you have Jaw/TMJ Pain?	❑	❑
Do you Grind or Clench your teeth?	❑	❑
Have you ever had Orthodontic Treatment?	❑	❑
If yes, do you have an Orthodontic Retainer?	❑	❑
Do you have a Night Guard?	❑	❑
How often do you wear it? _____		
PROSTHODONTICS:		
Do you have or have you had any of the following?		
Removable Dentures?	❑	❑
Removable Partial Dentures?	❑	❑
PERIODONTAL HISTORY:		
Do you have Bleeding, Swollen, or Irritated gums?	❑	❑
Do you have Loose, Tipped, or Shifting teeth?	❑	❑
Have you ever had Periodontal (gum) treatments?	❑	❑
Have you ever had Periodontal/Deep Cleanings?	❑	❑
ESTHETICS:		
If you could easily whiten your teeth, would you do it?	❑	❑

If I could change my smile, I would: (Check all that apply)

- ❑ Make them Whiter
- ❑ Make them Straigher
- ❑ Close Spaces
- ❑ Replace black metal fillings with Tooth Colored Restorations
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a Smile Makeover

ON A SCALE FROM 1-10 WITH 10 BEING THE HIGHEST RATING:

How would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

What do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

How did you hear about our office? _____

What is the most important thing to you about your future smile and dental work? _____

What is the most important thing to you about your dental visit today? _____

What can we do to make your visit more comfortable? _____

Patient Signature _____ Date _____

Form 0517