amersham dental care

NAME:__________________________________

1. Are you suffering any discomfort from your teeth?	YES	NO
2. Do you have a high number of restorations?	YES	NO
3. Do you find every time you attend a dentist you need another restoration?	YES	NO
4. Do you have any complex dental restorations such as implants or bridges?	YES	NO
5. Are you aware of bleeding gums?	YES	NO
6. Have you been told you have periodontal or “gum” disease?	YES	NO
7. Are you aware of bad breath or staining?	YES	NO
8. Do you wear a partial or full denture?	YES	NO
9. If yes are you happy with the fit and appearance?	YES	NO
10. Do you find attending a dental appointment is a nerve racking experience?	YES	NO
11. Are you happy with your smile?	YES	NO
12. Is there anything about the appearance of your teeth you would like to change (e.g the shape or colour)?	YES	NO
13. Do you play high impact sports?	YES	NO
14. Are you aware of clenching and/or grinding your teeth especially while asleep?	YES	NO