## **Your Personal Oral Health Assessment**



Would you like your Oral health assessed? Complete an Oral health assessment form to let us know what your teeth and gum concerns are. By answering our questions, we can see what dental risk category you are in and what can be done to help you. We are happy to contact you back with further information and answer your questions.

Please print, complo	ete the form and bring it me*	t to your next ap	pointment or a Email*	alternatively cli	ck to con	nplete it online. Phone	
*Required fields							
1. Your main concer	ns about your teet	h and gums	Vou may ti	ck more tha	n one:		
Want straighter	Would like a smile	_	e to improve	Chipped		nt whiter	
teeth	makeover		of front teeth	tooth/te		teeth Missing teeth	
Would like crov veneer	wn/ Replacement cro veneers		ted in Dental i bridges/dentur	mplants/	Vant stains moved from teeth	Would like a Dental Hygiene	
Other please say							
A little bit about yo 2. How long has it been s	_		l Exam?*				
3-6 months	6 months to 1 year	1-2 years	2-4 years	4-6 years	7 years plus	Never visited a dentist	
3. How long has it been s	since your last Dental by	giono?*					
3-6 months	6 months to 1 year	1-2 years	2-4 years	4-6 years	7 years	Never seen a hygienist	
					plus		
4. Do your gums bleed w	hen you brush?*		8. Do vo	u have anv bro	ken teeth or ca	avities that you know of?*	
Yes	No	Sometimes		Yes	No	-	
5. Do you know if you suffer from gum disease?*				9. Would you describe your sugar diet intake from drinks			
Yes No Unsure				and foods (included added sugars to beverages) as:			
				High	Medi	um Low	
C. Do way auffau fuana annu			10 Paul	*lo!l			
<ol><li>Do you suffer from any Yes</li></ol>	y sensitivity? No		10. Do ye	Yes	ay grind or cie No	nch your teeth?* O Unsure	
165	140						
7. Are you in dental pain at present? (Pain with eating or drinking hot/cold/sweet)*			11. Are y	11. Are you a smoker?*			
Yes	No			Yes	No		
						1	
If yes nies	ase specify					_	
ii yes piec	ase specify		-, I				