

PLEASE HANDLE ME WITH CARE



NAME _____

DATE _____

Thank you for providing us with important information that will help us serve you better.

Are you having any discomfort?	YES / NO	Have you ever been diagnosed with obstructive sleep apnea?	YES / NO
Any sensitivity to hot, cold, sweets, chewing	YES / NO	If so, are you interested in a conversation concerning your sleep?	YES / NO
Does dental treatment make you nervous?	YES / NO	Are you interested in being screened for obstructive sleep apnea for free?	YES / NO
Have you had a bad dental experience?	YES / NO	If I could change my smile I would...	
Does the noise of the drill bother you?	YES / NO	Make them whiter?	YES / NO
Does the noise of the picking or scraping bother you?	YES / NO	Make them straighter?	YES / NO
Do you feel out of control when lying in the dental chair?	YES / NO	Close spaces?	YES / NO
Have you had any of the following problems?		Replace silver fillings?	YES / NO
Bleeding gums?	YES / NO	Repair chipped teeth?	YES / NO
Bad breath?	YES / NO	Less gum showing?	YES / NO
Soreness in jaw joint?	YES / NO	Do you prefer to save your teeth?	YES / NO
Popping or Clicking in Jaw?	YES / NO	Would you be interested in having sedation?	YES / NO
Do you get headaches often?	YES / NO	Do you think your dental health effects your overall health?	YES / NO
Trouble getting numb?	YES / NO	On a scale of 1 to 10 with 10 being the highest rating:	
Gag easily?	YES / NO	How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
Bad taste in your mouth?	YES / NO	How would you rate your dental health now?	1 2 3 4 5 6 7 8 9 10
Do you wear dentures or partials? Are they comfortable?	YES / NO	Where would you like your dental health to be?	1 2 3 4 5 6 7 8 9 10
Does food get trapped and annoy you?	YES / NO		

DATE OF LAST CLEANING? _____

DATE OF LAST ORAL CANCER EXAM? _____

WHAT IS THE MOST IMPORTANT THING ABOUT YOUR DENTAL VISIT TODAY? _____



RAYMOND
DENTAL GROUP
FAMILY DENTISTRY & SEDATION CARE

*Your Comfort.
Your Smile.
Our Priority.*

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