Name: _____

Date: _____

When was your last visit with a dental hygienist? _____

Were X-rays taken at that time? Yes___ No___

How often do you brush? _____

Do you use a soft toothbrush? Yes____ No___ Electric brush Yes____No____

Do you floss? Yes___ No___ How often? _____

Do you use any other dental aids? Rubber tip, fluoride, Listerine? Yes___ No ___

Have you ever had orthodontic treatment (braces)? Yes___ No___

Do you have any teeth that are sensitive to hot/cold? Yes___ No___

If yes, which teeth? _____

Are any teeth sensitive to chew or bite with? Yes_____ No____

If yes, which ones? _____

Are you aware of a grinding or clenching habit? Yes____ No____

Do you wear a sports, night guard or retainer? Yes____ No___

Are you pleased with the appearance of your smile? Yes___ No___

If not, what would you like to change? _____

Are you pleased with their function? (Your ability to chew, eat.) Yes____ No____

Do you sip soda, juice, coffee or tea throughout the day? Yes____ No ____

Do you use candy or mints throughout the day? Yes____ No____

Do you drink bottle, tap or filtered water?_____

Do you smoke? Yes ___ No ___. If yes, how much? _____

Do you have any allergies to jewelry, food, medications? Yes____ No____

If yes, what allergy?_____

Who can we thank for referring you to our practice?

I Extraoral Exam

TMJ-clicking L – R popping L – R crepitus L – R

Mandibular opening: normal limited deviates L – R ____mm

Swelling lymphadenopathy

II Intraoral Exam

Oral cancer screen: cheeks, lips, tongue, floor of mouth WNL

Presence of pigmentation:

Presence of tauri: maxillary mandibular

Salivary flow: none moderate WNL

Mucogingival defects: teeth#

Frenum attachments: WNL other

Gingival recession: mild moderate severe none teeth#

Ortho: Class I II III crossbite L R

Overbite

Overjet

Open bite

Crowding

Rotations

Tilted Teeth

Abnormal wear of teeth

Presence of restorations/caries

Conditions of restorations

Perio probings

Oral hygiene: excellent good fair poor

III Perio Case type

I <3mm pockets; <u>gingivitis</u>: mild moderate severe no detectable bone loss
TX: scaling visit 40, 50, 60 minutes & review of Home Care (RHC)

II 3-4mm pockets; <u>slight periodontitis</u>, radiographic bone loss 1-20%
TX: 1-2 scaling visits, RHC & re-evaluation

III 4-7mm probings; <u>moderate periodontitis</u>, radiographic bone loss 20-50%, furcation involvement Class I or II, increase in mobility
TX: scaling & rootplaning quadrant, RHC x_____ visits and re-evaluation or Periodontist referral

IV >8mm probings; <u>severe periodontitis</u>, radiographic bone loss >50% significant tooth mobility, furcation Class II or III
TX: periodontal referral _____DDS __/__/____