Link Dental comprehensive restorative dentistry

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Dental Self- Assessment Questionnaire:

Functional Issues:

1.	Are your jaw joints ever painful?	Never	Sometimes	Always
2.	Do your jaw joints make noises, Clicking, popping, grating?	Yes	No	
3.	Does your mouth ever lock in an open or closed position?	Yes	No	
4.	Does your jaw catch or lock open or closed?	Yes	No	
5.	Does your jaw feel limited or tight in motion?	Yes	No	
6.	Do you avoid eating certain foods due to discomfort?	Yes	No	
7.	Do you get frequent Head Aches?	Yes	No	
8.	Do you Clench or Grind your teeth?	Yes	No	
9.	Have you ever suffered unexplained fractures of your teeth?	Yes	No	
10.	Are your teeth severely worn?	Yes	No	
11.	Are your teeth sensitive to hot, cold or sweets?	Yes	No	
12.	Are your teeth severely Worn/shorter than they use to be?	Yes	No	
13.	Do you have grooves or notches along the root surfaces?	Yes	No	
14.	Have you ever had a major trauma to your jaw/teeth?	Yes	No	
15.	Do you Snore?	Yes	No	
16.	Do you feel rested upon waking in the morning?	Yes	No	
17.	Do you ever stop breathing during your sleep?	Yes	No	
18.	Have you ever had braces or been told you need them?	Yes	No	

Biologic Issues:

1. Do your gums bleed when your brush them? Yes No
2. Have your gums receded so the roots of your teeth show? Yes No
3. Have you ever needed deep cleaning of your teeth? Yes No
4. Have you ever had surgery on your gums? Yes No
5. Have you ever lost teeth due to gum disease? Yes No
6. Does food frequently get caught between your teeth? Yes No
7. Do you get frequent cold sores on your lips? Yes No
8. Do you get frequent canker sores in your mouth? Yes No
9. Have you had a lot of cavities/fillings in the past? Yes No
10. Have you ever had a root canal before? Yes No
11. Does your mouth seem too dry? Yes No

Esthetic Issues:

1. Are you generally pleased with your smile? Yes No
2. Do you ever avoid smiling fully out of concern for the appearance of your teeth? Yes No
3. Are you happy with the color of your teeth? Yes No
4. Do you feel your smile is too "gummy"? Yes No
5. Do you feel your teeth are too short? Yes No
6. Do you feel your teeth are too long? Yes No
7. Do you feel your teeth are too crowded? Yes No
8. Do you feel your teeth are too spaced? Yes No

Please circle the paragraph below that best characterizes the level of dental care you would like to have:

Level 1...URGENT CARE People in crisis or with an emergency problem such as pain, swelling, or bleeding that need our immediate help are at this level.

Level 2...SELF-CARE Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose repair solutions that are short range in nature.

Level 3...COMPLETE DENTISTRY Patients at this level are similar to people described in level 2. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion possible.

Level 4... LOOK YOUR BEST People in this group are in level 3 as far as dental health is concerned, but also want to look their best at all times. They know that their smile is the first things others notice about them and want to put their best smile forward.