DENTAL INFORMATION

Former Dentist ______________________________ Phone # ______________________

Address ______________________________ City ______________ State ________ ZIP ____________

Date of last dental visit ______________ Date of last x-rays ________________

DENTAL HISTORY

How may we help you this visit? ______________________________

Are you currently in pain? **YES** ☐ **NO** ☐ **Where?** ______________________

Have you experienced problems associated with any previous dental work? **YES** ☐ **NO** ☐

If yes, explain: ______________________________

Do you have frequent headaches? **YES** ☐ **NO** ☐

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ or TMD)? **YES** ☐ **NO** ☐

Your current dental health is Good ☐ Fair ☐ Poor ☐

Do you floss daily? **YES** ☐ **NO** ☐ Do you brush daily? **YES** ☐ **NO** ☐

How long do you use a toothbrush before replacing it? ______________________

Do you use anything in addition to your brush and floss? **YES** ☐ **NO** ☐

If yes, explain ______________________________

Do your gums bleed? **YES** ☐ **NO** ☐

Have you ever been told that you have Periodontal Disease? **YES** ☐ **NO** ☐

Are any teeth loose? **YES** ☐ **NO** ☐

Do you grind or clench your teeth? **YES** ☐ **NO** ☐

Does food get caught between your teeth in any specific area? **YES** ☐ **NO** ☐ Where? ______________

Are your teeth sensitive to heat, cold or anything else? **YES** ☐ **NO** ☐

If yes, explain ______________________________

Have you lost any teeth? **YES** ☐ **NO** ☐ If yes, explain ______________________

Are you happy with the way your smile looks? **YES** ☐ **NO** ☐

If not, what would you change? ______________________________

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Have you been told that you snore? **YES** ☐ **NO** ☐

Would you be interested in learning more about:

Teeth Bleaching .... ☐ Amalgam Removal........... ☐ Cosmetic Dentistry .... ☐

Teeth Straightening........... ☐ Snore Appliance .... ☐ Sports Guards.................... ☐