DENTAL HEALTH INFORMATION

Previous Dentist: ______________________________ Date last treated ______________

What is the reason for your visit today? ______________________________

Do you presently have dental pain or discomfort? Please describe: ______________________________

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Have you ever had any serious problem associated with dental treatment? ---------------------- ☐ Yes ☐ No

If yes, please explain: ______________________________

How often do you brush your teeth? ____________ How often do you floss your teeth? ______________

What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Electric

Have you had injuries to your face, neck or jaw? --- ☐ Yes ☐ No

Do you have problems with food catching between your teeth when you eat? ----------------- ☐ Yes ☐ No

DO YOU HAVE OR HAVE YOU EVER HAD: (circle)

Gums that bleed when you brush or floss?	Have Now	Have Had	Don't Have
Gums that are swollen or tender?	Have Now	Have Had	Don't Have
Pain in any of your teeth when brushing or flossing?	Have Now	Have Had	Don't Have
Treatment for periodontal (gum) disease?	Have Now	Have Had	Don't Have
Pain when your teeth come in contact with hot or cold foods?	Have Now	Have Had	Don't Have
Orthodontic treatment?	Have Now	Have Had	Don't Have
Pain, clicking or popping in your jaw joints?	Have Now	Have Had	Don't Have
Clench or grind your teeth while sleeping or during the day?	Have Now	Have Had	Don't Have
Difficulty opening or closing your mouth?	Have Now	Have Had	Don't Have

Do you like the appearance of your teeth? --- ☐ Yes ☐ No

If no, what would you like to see different? ______________________________

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Is there any treatment that was recommended by another dentist that was not completed? ------ ☐ Yes ☐ No

Do you expect to maintain your teeth for your lifetime? -- ☐ Yes ☐ No

Do you have any particular concerns about the materials used to restore your teeth? ______________

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Is there anything else that you would like the Doctor to be aware of concerning your past or present dental health? _____

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