Dental History

What would you like us to do today?________________________________

Are you in dental discomfort today?_________________________________

Former Dentist_________________Address__________________________

Dentist's Email___________________________Phone_________________

Date of last dental care______________Date of last X-rays_____________

Please mark if you have had any of the following:

___Bad Breath
___Bleeding Gums
___Grinding or Clenching of Teeth
___Periodontal Treatment
___Sensitivity to Sweets
___Sensitivity when Biting
___Food Collecting between Teeth
___Clicking of popping of jaw
___Loose teeth or broken fillings
___Sensitivity to Cold
___Sensitivity to Hot
___Sores or Growths in Mouth

How often do you brush?________________Floss?___________________

How do you feel about the appearance of your teeth?__________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?_________________________________

Other Information about your dental health or previous treatment_________
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