Medical and Dental Information

Date of last Dental Visit _____ Former Dentist _____

Address _____ Phone _____

Last Dental x-rays _____

What would you like us to do today? _____

Dental History

Please Circle yes or no:

Do your gums bleed while brushing or Flossing? ..... YES NO

Does food tend to become caught between your teeth?..... YES NO

Are your teeth sensitive to hot, cold, sweet, or sour liquids/foods?.....YES NO

Have you ever experienced any of the following problems in your jaw?
- Clicking.....YES NO
- Pain (joint, ear, side of face).....YES NO

Difficulty in opening or closing.....YES NO
Difficulty in chewing?..... YES NO
Do you clench or grind your teeth?.....YES NO
Do wish your teeth were whiter? ..... YES NO
Do you ever worry you have bad breath? YES NO
Do you suffer from cold sores or canker Sores?.....YES NO

Have you ever considered braces?.....YES NO

Have you ever had periodontal Treatment?.....YES NO

Ever worn a bite plate or other appliance?.....YES NO

Have you ever had any difficult extractions in the past?.....YES NO

Do your teeth embarrass you when you smile?.....YES NO
Do you have gaps or spaces between your teeth?.....YES NO
Do you have frequent headaches? YES NO
Do bite your lips or cheeks frequently?.....YES NO

Do you dread family photos?.....YES NO
Do you cover your mouth when you speak?.....YES NO
Do you think your smile shows too much gum tissue? .....YES NO

If you could change anything about your smile, what would you change?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH

X_____
SIGNATURE OF PATIENT OR PARENT IF MINOR

_____
DATE

X_____
PRINTED NAME OF PATIENT OR PARENT IF MINOR