

## DENTAL INFORMATION

Patient: \_\_\_\_\_

Name and phone number of previous dentist \_\_\_\_\_

Date of your last dental exam \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Do your gums bleed when you brush or floss? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Are your teeth sensitive to hot, cold, sweets or pressure? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Does food or floss catch between your teeth? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Is your mouth dry? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Have you been diagnosed with periodontal disease? \_\_\_\_\_ yes \_\_\_ no \_\_\_

    If so, have you ever had scaling and root planing? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Have you had orthodontic (braces) treatment? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you have any dental phobias? \_\_\_\_\_ yes \_\_\_ no \_\_\_

    If yes please explain \_\_\_\_\_

Have you had any problems with dental anesthesia? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Have you had any problems associated with previous dental treatment? \_\_\_ yes \_\_\_ no \_\_\_

    If yes please explain \_\_\_\_\_

Are you currently experiencing any dental pain or discomfort? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you have earaches or neck pain? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you have clicking, popping or discomfort in the jaw? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you brux or grind your teeth? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you have sores or ulcers in your mouth? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Do you wear dentures or partials? \_\_\_\_\_ yes \_\_\_ no \_\_\_

What is the reason for your visit today? \_\_\_\_\_

Are you interested in teeth whitening? \_\_\_\_\_ yes \_\_\_ no \_\_\_

Are you interested in changing the appearance of your teeth? \_\_\_\_\_ yes \_\_\_ no \_\_\_