Dental Information *For the following questions, please Mark an (X) for your response*

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following Questions.

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth? Circle Where? UR LR UL LL	☐	☐
Is your mouth dry?...	☐	☐
Have you had any periodontal (gum) treatments?..........................	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Have you ever had a serious injury to your head or mouth?...........	☐	☐
Do you have broken fillings or teeth?	☐	☐
Are you currently experiencing dental pain or discomfort?..	☐	☐
Have you had any problems associated with previous dental Treatment?..................................	☐	☐

	Yes	No
Do you have headaches, earaches, neck or jaw joint pain?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you use over the counter pain medication or sleeping aids?	☐	☐
Can you get to sleep?	☐	☐
Can you sleep through the night without waking?	☐	☐
Do you wake rested?	☐	☐
Do you wear dentures or partials?	☐	☐

Date of your last dental exam:

Date of your last cleaning:

Date of last dental x-rays:

Name of Previous Dentist:

City: State:

Why did you leave your previous dentist?

How did you hear about our office?

What is the reason for your dental visit today?

If I could change my smile, I would:

- Make my teeth Whiter ☐
- Make my teeth straighter ☐
- Close Spaces ☐
- Replace Metal filings with tooth Colored restorations ☐
- Repair chipped teeth ☐
- Replace missing teeth ☐
- Replace crowns that don't match ☐
- Have a smile makeover ☐