

PLEASE TELL US A FEW INTERESTING FACTS ABOUT YOURSELF
(HOBBIES, ACTIVITIES etc)

- 1.
- 2.
- 3.
- 4.
- 5.

DENTAL HISTORY:

REASON FOR TODAY'S VISIT _____
FORMER DENTIST _____
FORMER DENTIST PHONE# _____
DATE OF LAST DENTAL VISIT _____
DATE OF LAST DENTAL XRAYS _____
HAVE YOU HAD ANY BAD DENTAL EXPERIENCES, IS SO WHAT? _____
HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING BY CHECKING THE
APPROPRIATE LINE:

BAD BREATH _____	FOOD IMPACTION _____
BLEEDING GUMS _____	GRINDING TEETH _____
BLISTER ON LIPS OR MOUTH _____	GUMS SWOLLEN OR TENDER _____
BURNING SENSATION ON TOUNGE _____	JAW PAIN OR TIREDNESS _____
CHEW ON ONE SIDE OF MOUTH _____	LIP OR CHEEK BITING _____
CIGARETTE, PIPE, OR CIGAR SMOKING _____	LOOSE TEETH OR BROKEN TEETH _____
CLICKING OR POPPING JAW _____	MOUTH BREATHING _____
DRY MOUTH _____	PAIN AROUND EAR _____
FINGERNAIL BITING _____	ORTHODONTIC TREATMENT _____
SENSITIVITY TO COLD _____	PERIODONTAL TREATMENT _____
SENSITIVITY TO HOT _____	SORES/GROWTHS IN YOUR MOUTH _____
SENSITIVITY TO SWEET _____	SENSITIVITY WHEN BITING _____