

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__ |