Dental History

How may we help you today? _____

When was you last dental visit? _____

When was your last dental cleaning? _____

Why did you leave your last dentist? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or anything else? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes when? _____ ☐ No

How many times do you: Floss/week? _____ Brush/day? _____

Do you have any pain/discomfort in your jaw joint? ☐ Yes ☐ No

Are you under more stress than usual? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

How can we better accommodate you during your dental visit? _____

_____

We offer a wide range of services to maintain and enhance your smile. Please circle any services below that you would like to discuss during your visit.

Tooth Whitening	**Bonding**	**Partials/Dentures**
Invisalign	**Implants / Implant crowns**	**Crown and Bridge**
Sealants	**Night/Sport Guards**	**Tooth Colored Fillings**