DENTAL HISTORY

1. Why have you come to the dentist today?_____
2. Are you currently in pain? □ Yes □ No
3. Do you require antibiotics before dental treatment? □ Yes □ No
4. Have you experienced problems associated with any previous dental work? □ Yes □ No
5. Do you now or have you ever experienced pain/discomfort in your jaw joint?
   □ Yes □ No
6. Do you floss daily? □ Yes □ No
7. Brush daily? □ Yes □ No
8. Your current dental health is? □ Good □ Fair □ Poor
9. What types of bristles are on your toothbrush? □ Hard □ Medium □ Soft
10. Do you use anything additional on your brush or floss? □ Yes □ No
    If yes, what?

11. Would you like a fresher breath? □ Yes □ No
12. Whiter teeth? □ Yes □ No
13. Do your gums ever bleed? □ Yes □ No Ever itchy? □ Yes □ No
14. Would you like to know more information on Oral Cancer? □ Yes □ No
15. Have you ever had periodontal disease? □ Yes □ No
16. Are your teeth sensitive to heat, cold, or anything else? □ Yes □ No
17. Do you still have wisdom teeth? □Yes □ No
    If yes, why? _____
18. Are you happy with the way your smile looks? □ Yes □ No
    If not what would you like to change? _____

19. Previous/Present Dentist: _____ Last date of visit:_____
20. Why did you leave your previous dentist?_____
21. How did you hear about our office? _____
22. Are you interested in a 24 month no interest payment option? □ Yes □ No