Dental Information

Purpose of visit _____

How long since your last dental visit? _____ Previous Dentist _____

Were dental x-rays taken recently? Y/N Does food get caught between your teeth? Y/N

Have any teeth been removed? Y/N Why? _____ Have they been replaced? Y/N

Is there any pain or soreness in the muscles of your face or around your ears? Y/N

Do you clench or grind your teeth? Y/N Does your jaw click or pop? Y/N

Do you get headaches often? Y/N If so, do they occur in the morning, afternoon, or evening? _____

Are any of your teeth sensitive to : Hot _____ Cold _____ Sweets _____ Pressure _____

How often do you brush your teeth? _____ When? _____

Do you floss? Y/N How often? _____

Are you happy with the appearance of your teeth? Y/N Do you feel that they are white enough? Y/N

Is there anything that you would like to change about your smile? Y/N

If yes, could you elaborate: _____

Do you feel that your breath is as fresh as it could be? Y/N

How do you feel about your teeth in general?

_____

_____

Have you had any unpleasant dental experiences? Y/N

If yes, please elaborate: _____

Do you have any specific questions that you would like us to address? _____

_____