DENTAL INFORMATION

What is the purpose of this appointment? _____

Do you have dental pain at this time? Severe ☐ Moderate ☐ Slight ☐ None ☐

Date of last dental visit: _____ Last dental cleaning: _____

Does dental treatment make you anxious? Extremely ☐ Moderately ☐ Slightly ☐ No ☐

Do you have or have you had any of the following: Please circle all that apply:

Bleeding, sore gums Unpleasant taste, bad breath Loose teeth Burning tongue, lips Swollen gums

Frequent blisters on lips or mouth Swelling or lumps in mouth Difficulty opening or closing jaw

Orthodontic treatment Clicking, popping jaw Clenching or grinding Food impaction TMJ

Tired jaws Dry mouth Uncomfortable bite Floss catches Change in bite

Sensitive to: Hot Cold Sweets Biting Chewing

If you circled any of the above please explain: _____

_____

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐

If not, what is it you would like to change? _____

Name of previous dentist: _____ May we contact that office for records? Yes ☐ No ☐

What, if any, premedications have been recommended for you to take prior to dental appointments? _____

_____

Have you had difficulty or problems with past dental treatment experiences. If so, please explain.

_____

_____