Dental History

Y N

Are your teeth sensitive to?

____ ____ Heat
____ ____ Cold
____ ____ Sweets
____ ____ Biting Pressure

____ ____ Does food constantly get stuck between certain teeth in your mouth?

____ ____ Are you dissatisfied with your teeth in any way?

____ ____ Are you dissatisfied with the way your teeth look? For example: color, shape, spaces, ect.

____ ____ Do any of your fillings show in your front teeth?

____ ____ Do any of your fillings show when you smile?

____ ____ If any of your mercury metal fllings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?

____ ____ Have you ever had any teeth removed?

____ ____ Do you play Sports, if yes what type _____

Y N

____ ____ Do your gums bleed when brushing?

____ ____ Do you avoid any part of your mouth when brushing?

____ ____ Have you been instructed regarding proper oral hygiene?

____ ____ Do you have an upleasant taste or odor in your mouth?

____ ____ Do you frequently snack on sweets or chew gum?

____ ____ Do you have a concern about fear or discomfort?

When was your last dental appointment?_____

How long has it been since you have had a full series of x-rays?_____

What has prompted you to seek dental care at this time?_____