DENTAL INFORMATION

Do your gums bleed when you brush or floss?	YES	NO
Are your teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Does food or floss catch between your teeth?	YES	NO
Is your mouth dry?	YES	NO
Have you ever had any periodontal (gum) treatments?	YES	NO
Have you ever had any problems associated with previous dental treatments?	YES	NO
Have you ever had orthodontic (braces) treatment?	YES	NO
Are you currently experiencing dental pain or discomfort?	YES	NO
Do you have earaches or neck pain?	YES	NO
Do you have any clicking, popping or discomfort in your jaw?	YES	NO
Do you brux or grind your teeth?	YES	NO
Do you have sores or ulcers in your mouth?	YES	NO
Do you wear dentures or partials?	YES	NO
Have you ever had a serious injury to your head or mouth?	YES	NO

Date of your last exam: _____

Date of your last dental x-rays: _____

What is the reason for your dental visit today? _____

How to do you feel about your smile? _____

Signature of patient (or parent) _____ Date _____