

DENTAL HISTORY

Are You Having a Specific Dental Problem? _____ Duration _____

When Was Your Last Dental Appointment? _____

Purpose _____

Did You Have X-Rays at That Time? _____

How Often Do You Have Your Teeth Cleaned/Examined? _____

What Is Your Reaction To Have Dental Work Done? Don't Mind It Worry About It Dread It

Have You Ever Had Your Teeth Straightened? _____

Do You Like Your Smile? _____

Would You Like To Have Whiter Teeth? _____

Have You Lost Any Teeth? _____ Were They Replaced? _____

How Would You Describe Your Present Dental Health? Good Fair Poor

Are Any Teeth Sensitive to Heat, Cold, Pressure and/or Sweets? _____

Have You Ever Been Told You Have a Bite Problem? _____

Do You Have Any Pain in the Area of Your Ear? _____

Do You Hear Popping, Clicking or Snapping Noises When You Chew? _____

Do Your Gums Bleed When Brushing? _____

Have Your Gums Ever Been Treated? _____

How Often Do You Brush Your Teeth? _____

Do You Use Floss, Stimulator, Water Jet _____

Have You Ever Been Shown Plaque Control Methods? _____

Do You Have Any Oral Habits Such As: Cheek Biting Tongue Thrusting Nail Biting Teeth Grinding

Finger Sucking Mouth Breathing Others _____

What Do You Hope We Will Be Able to Accomplish For You? _____

Thank You For Furnishing Us With the Above Information