Dental Health History

Are you having any current dental problems or concerns:_____

When was your last dental visit:_____

When was your last dental cleaning:_____

How often do you brush your teeth:_____

What texture toothbrush do you use: Soft _____ Medium_____ Hard_____

Would you be interested in any of our bleaching techniques: Yes_____ No_____

	Yes	No
Do your gums bleed while brushing:	_____	_____
Do you feel pain in any of your teeth while brushing or flossing?	_____	_____
Are your teeth sensitive to hot, cold, or sweet foods?	_____	_____
Have you noticed any loosening of your teeth?	_____	_____
Do you have any sores in your mouth?	_____	_____

Have you ever experienced any of the following problems in your jaw:

1. Clicking	_____	_____
2. Pain (joint, ear, side of face)	_____	_____
3. Difficulty opening or closing	_____	_____

Have you ever had any head, neck, or jaw injuries? _____ _____

Dental Health History

Do you have frequent headaches? _____
_____

Do you clench or grind your teeth while awake or asleep? _____
_____

Have you ever had:

1. Braces _____
   _____
2. Oral Surgery _____
   _____
3. Gum Treatment _____
   _____
4. Your teeth ground or the bite adjusted _____
   _____
5. Worn an appliance _____
   _____

Do you smoke or use tobacco products (snuff)? _____
_____

Do you use any non-prescription drugs or herbal supplements? _____
_____

Do you take weight-loss meds? _____
_____

Do you consume grapefruit or grapefruit juice? _____
_____