Name _____ Date_____

Please state your reason for seeking dental care at this time?

Do you have discomfort in your mouth? Y N

Do you like to see a dentist regulary? Y N

Are happy with your smile? Y N

Do your gums bleed? Y N

How long since your last cleaning? _____

Do you have sensitivity to hot, cold, sweets, or pressure? Y N

Are you apprehensive about your dental treatment? Y N

How long since your last dental visit? _____

On a scale of 1-10, how healthy do you feel your mouth is? _____

Have you had any problems or complications with any previous dental treatment? Y N

Would you like whiter teeth? Y N

Please state _____

History: Past &/or Present

braces, extractions, root canals, dental implants, gum surgery/ treatment, trauma

jaw pain, jaw pops, sores/growths/ulcers, grinding, clenching, headaches, snoring,

sleep apnea, allergies, crooked teeth, mouth breather

Child's History: Past &/or Present

braces, extractions, trauma, mouth sores, mouth breather, chapped lips, speech problems,

curious tongue, snoring, bed wetting, toss & turn at night, wakes frequently at night,

frequent nightmares, grinding, dark circles under eyes, headaches, earaches,

frequent sore throat, pacifier, thumb sucker, allergies, attention problems