DENTAL HISTORY

REASON FOR VISIT: _____

DATE OF LAST DENTAL VISIT: _____ DATE OF LAST DENTAL X-RAYS: _____

HOW OFTEN DO YOU FLOSS?: _____ HOW OFTEN DO YOU BRUSH?: _____

(PLEASE CHECK ALL THAT APPLY)

- ☐ BAD BREATH
- ☐ BLEEDING, RED, SWOLLEN GUMS
- ☐ BROKEN/LOOSE TEETH OR FILLINGS
- ☐ CLICKING OR POPPING JAW
- ☐ GRINDING TEETH
- ☐ PAIN AROUND EAR/SIDE OF FACE
- ☐ SORES/BLISTERS IN MOUTH

LIST ANY OTHER DENTAL CONCERNS/PAIN: _____

WHAT DID YOU LIKE THE MOST ABOUT YOUR PREVIOUS DENTAL OFFICE?:

WHAT DID YOU LIKE THE LEAST ABOUT YOUR PREVIOUS DENTAL OFFICE?:

ARE YOU INTERESTED IN WHITENING YOUR SMILE?

ARE YOU HAPPY WITH YOUR SMILE? IF NOT, WHAT WOULD YOU CHANGE?: