Dental Health Information

Date of Last Dental Visit: _____

Previous Dentist: _____

Referred By: _____

Reason for Today's Visit: _____

_____

Have you ever had any dental complications following dental treatment?
Yes or No
If yes, please explain: _____

_____

Are you happy with your smile?
Yes or No
If no, what would you like to achieve? _____

_____

How often do you brush? _____ Floss? _____

Do you clench or grind your teeth during the day or while sleeping? Yes or No

Do you smoke or use chewing tobacco? Yes or No

Do you drink a lot of coffee, tea or soda? Yes or No

Do your gums bleed while brushing or flossing? Yes or No

Do your gums feel tender or swollen? Yes or No

Are you interested in cosmetic dentistry? Yes or No

Are you interested in Bleaching? Yes or No