DENTAL HISTORY

Former Dentist ____

Date of Last Visit ____

Medical History (please list) ____

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Dental Concerns (please list) ____

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Yes No Are you currently experiencing any dental pain?

Yes No Do you have any pre-existing dental conditions?

Yes No Are your teeth or mouth sensitive to temperature?

Yes No Do your gums bleed when brushing or flossing?

Yes No Are you aware if you grind your teeth?

Yes No Have you experienced any jaw popping or clenching?

Yes No Are you interested in cosmetic dentistry?

RELEASE SIGNATURE

Signature ____