

**DENTAL INFORMATION**

What is your immediate concern? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything about the appearance of your smile that you would like to change?

**Check all that apply:**

- Had complications from past dental treatment ..... Y  N
- Had trouble getting numb ..... Y  N
- Had any reactions to local anesthetic ..... Y  N
- Had/have braces, orthodontic treatment ..... Y  N
- You experience dry mouth ..... Y  N
- Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth ..... Y  N
- Food gets trapped between any teeth ..... Y  N
- Have you ever whitened or bleached your teeth ..... Y  N
- Have you experienced popping and/or clicking of your jaw joint ..... Y  N
- You have difficulty chewing ..... Y  N
- You clench or grind your teeth ..... Y  N
- You wear or have worn a bite appliance ..... Y  N
- Gums bleed when brushing or flossing ..... Y  N
- Treated for gum disease or were told you have lost bone around your teeth ..... Y  N
- Noticed an unpleasant taste or odor in your mouth ..... Y  N
- Experienced gum recession ..... Y  N
- Had any teeth become loose on their own (without injury) ..... Y  N
- Experienced a burning sensation in your mouth ..... Y  N
- You snore or wake up frequently during the night ..... Y  N

If any of the checked boxes need further explanation, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_