Dental Health

When was your last dental Visit?

How often do you brush_floss your teeth?

What texture brush do you use? Soft Medium Hard

Do your gums feel tender or swollen? ◯ Yes ◯ No

Do you experience dry mouth? ◯ Yes ◯ No

Do you gag easliy? ◯ Yes ◯ No

Have you ever experienced any of the following problems with your jaw?

Clicking? ◯ Yes ◯ No

Difficulty opening or closing? ◯ Yes ◯ No

Pain in joint or side of face? ◯ Yes ◯ No

Difficulty chewing ◯ Yes ◯ No

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

Do you have frequent headaches? ◯ Yes ◯ No

Are you nervous about your treatment? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Office Notes Only

Uses Carbocaine ◯ Yes ◯ No

String/ No Epinephrine ◯ Yes ◯ No

Numbing needs extra time ◯ Yes ◯ No

Uses N2O ◯ Yes ◯ No

Patient is on Blood Thinner ◯ Yes ◯ No

CA channel blocker ◯ Yes ◯ No

Take X-rays at every hygiene appt ◯ Yes ◯ No