

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?
- Do you experience dry mouth?
- Have you ever had any head, neck, or jaw injuries?
- Do you gag easily?

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

- clicking Yes No
- Difficulty opening or closing Yes No
- Pain in joint or side of face Yes No
- Difficulty in chewing Yes No

Do you clench or grind your teeth while sleeping or during the day?

Do you have frequent headaches? Yes No

Are you nervous about your treatment?

Have you every had Nitrous Oxide? Yes No

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: _____