Moossy
GENERAL & COSMETIC DENTISTRY

DENTAL INFORMATION

Name_____
FORMER DENTIST _____
CITY/STATE_____
DATE OF LAST DENTAL CARE _____
HAVE YOU HAD DENTAL X-RAYS IN THE LAST YEAR? IF YES, WHERE
_____
WHAT WOULD YOU LIKE FOR US TO DO FOR YOU TODAY?
_____
_____
_____

ARE YOU HAVING ANY DISCOMFORT?
_____

DO YOU HAVE ANY FAMILY HISTORY OF GUM DISEASE OR RECEDING GUMS? IF YES, PLEASE EXPLAIN
_____

PLEASE CIRCLE IF YOU HAVE HAD ANY PROBLEMS WITH THE FOLLOWING:

BAD BREATH
BLEEDING GUM
CLICKING OR POPPING JAW
FOOD COLLECTION BETWEEN TEETH
GRINDING OR CLENCHING OF TEETH
LOOSE TEETH OR BROKEN FILLINGS
PERIODONTAL TREATMENT
RECEDING GUMS
SENSITIVITY TO HOT
SENSITIVITY TO COLD
SENSITIVITY TO SWEETS
SENSITIVITY TO BITING
SORES OR GROWTHS IN MOUTH

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH?
_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHAT WOULD IT BE?
_____

HAVE YOU EVER EXPERIENCED AN ADVERSE REACTION DURING OR IN CONJUNCTION WITH A MEDICAL OR DENTAL PROCEDURE?
_____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

DO YOU USE ANY TOOLS BETWEEN YOUR TEETH?
_____