Please mark any of the following to indicate 'YES' in response to the question

- ☐ Have you ever had complications following dental treatment?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to hot or cold temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partial?

If you could change anything about your mouth, teeth, or smile, what would it be?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date? _____

Are you allergic to or have you reacted adversely to any of the following medications?

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Erythromycin
- ☐ Latex
- ☐ Nitrous Oxide
- ☐ Codeine
- ☐ Penicillin
- ☐ Other_____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature: _____ Date: _____

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never