DENTAL QUESTIONS

Physician's Name ____

Physician's Address ____

Physician's Phone # ______________________ Date of last visit ____________

Reason for Today's Visit ____________________________________

Previous Dentist ____

Address ____

Date of last dental care ______________________________________

Date of last dental X-rays ____________________________________

Check if you have or have experienced any of the following:

_____ Bad Breath
_____ Food collecting between teeth
_____ Sensitivity to hot
_____ Bleeding Gums
_____ Loose Teeth or Broken Fillings
_____ Sensitivity to sweets
_____ Clicking or popping jaw
_____ Periodontal treatment
_____ Sensitivity when biting
_____ Grinding Teeth
_____ Sores or growths in your mouth
_____ Sensitivity to cold
_____ Problems with sensitivity to local anesthetics

How often do you brush your teeth? __________ How often do you floss? __________

Are you happy with the appearance of your teeth? YES NO
Would you like your teeth straighter? YES NO
Would you like your teeth whiter? YES NO

Do you snore? YES NO
Have you ever been told that you have Sleep Apnea? YES NO
Do you, or are you instructed to use a CPAP machine to help you sleep? YES NO