

DENTAL HEALTH HISTORY

WHEN WAS YOUR LAST DENTAL EXAMINATION: _____ LAST CLEANING _____

CHECK ALL THAT APPLY

TENDER GUMS WHILE CHEWING BLEEDING GUMS BAD BREATH SORE AREAS IN YOUR MOUTH

PAIN IN OR NEAR EARS SPACE DEVELOPING BETWEEN TEETH SENSITIVITY TO HOT, COLD, SWEETS TOOTHACHE

HAVE YOU BEEN TREATED BY A PERIODONTIST (GUM SPECIALIST): YES OR NO ORTHO _____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH: YES OR NO IF NOT WHY:

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT: YES OR NO

ARE YOU CURRENTLY TAKING VITAMINS OR CBD PRODUCTS? _____

PREFERRED PHARMACY _____

HAVE YOU RECEIVED THE COVID-19 VACCINES?/ NONE /YES OR NO /

J AND J/ MODERNA/ PFIZER /

1ST Date _____ 2ND Date _____ BOOSTER Date _____

HOME CARE

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____ FLOSS _____

WHAT KIND OF BRUSH DO YOU USE: MANUAL ELECTRIC

WHAT TEXTURE OF BRUSH DO YOU USE: SOFT MEDIUM HARD

DO YOU SUFFER FROM MIGRAINES: YES OR NO DO YOU SNORE? _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS CORRECT. I WILL INFORM YOU IF ANY CHANGES IN MY HEALTH OR MEDICATIONS SHOULD OCCUR.

SIGNATURE: _____ DATE: _____