Patient Forms

Dental History

BITE AND JAW JOINT:	YES	NO
18. Do you have tension headaches or sore teeth? _____		
19. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years? _____	☐	☐
21. Do you have a dry mouth? _____	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
24. Do you avoid brushing any part of your mouth? _____	☐	☐
GUM AND BONE		
25. Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
26. Have you ever experienced gum recession? _____	☐	☐
27. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
28. Do your gums bleed when brushing, flossing, or eating? _____	☐	☐
29. Are your teeth becoming loose? _____	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
31. Have you experienced or burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Call today 561-844-0715 | 4600 Military Trail #219 | Jupiter, FL 33458