Dental Treatment

10. Have you ever had any serious trouble associated with previous dental treatment? Y N
    If so, explain____
    ____

11. Does dental treatment make you nervous? Y N
12. Date of last dental visit_________________________
13. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ____

14. Do you or have you ever had any of the following:

Bleeding/sore gums	Y	N	Loose teeth	Y	N
Unpleasant taste/bad breath	Y	N	Sensitive to hot	Y	N
Burning tongue/lips	Y	N	Sensitive to cold	Y	N
Frequent blisters, lips/mouth	Y	N	Sensitive to sweets	Y	N
Ortho treatment (braces)	Y	N	Sensitive to biting	Y	N
Biting cheeks/lips	Y	N	Food impaction	Y	N
Clicking/popping jaw	Y	N	Clenching/grinding	Y	N
Difficulty opening or closing	Y	N	Shifting of teeth	Y	N
Swelling/lumps in mouth	Y	N	Change in bite	Y	N

15. Oral Hygiene- Do you use the following?

Toothbrush	Y	N	How often do you brush?____________
Dental floss	Y	N	Brush is Soft___Med____Hard______
Fluoride rinse	Y	N	How often do you floss?_____________
			Floss is waxed_______unwaxed________
			Brand name________________________

Other Oral Hygiene Products you use:_______________________________________

16. If you could change anything about your smile, what would you change?_______________________
    ____

The information given about my health history in this form is accurate to the best of my knowledge.
I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health.

____ ____________________
Signature of patient, parent or guardian Date