

DENTAL HISTORY

First Name: _____ Last Name: _____ Birthday: _____

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (new job,moving,relationships) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times a do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Focus Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please check any services below you would like our friendly staff to discuss with you during your visit.

- | | | |
|--|---|---|
| <input type="checkbox"/> Opalescence Tooth Whitening | <input type="checkbox"/> Veneers | <input type="checkbox"/> Invisalign |
| <input type="checkbox"/> Traditional Orthodontics (Brackets) | <input type="checkbox"/> Implant Crowns | <input type="checkbox"/> Bonding |
| <input type="checkbox"/> Sealants | <input type="checkbox"/> Crown and Bridge | <input type="checkbox"/> Night/Sport Guards |
| <input type="checkbox"/> Partial/Dentures | | |