DENTAL HISTORY

GLENN N. PHILLIPS, DMD **ANDREW W. PHILLIPS, DMD**

Do you have specific dental problems? _____

_____

Previous dentist _____ When was last visit? _____

How often do you brush your teeth? _____ Floss? _____

Have you lost any teeth? _____ Why? _____

Do your gums hurt or bleed when brushing? _____ Flossing? _____

Have you had periodontal (gum) work? _____ Orthodontics (braces)? _____

Are any of your teeth loose? _____

Does food get caught between your teeth? _____

Have you had problems with local anesthetics (dental injections)? _____

Are your teeth sensitive to hot? _____ Cold? _____ Sweets? _____ Pressure? _____

Do you clench or grind your teeth? _____ During sleep? _____

Do you have difficulty chewing? _____ or swallowing? _____

Have you had problems with your occlusion ("bite") _____ worn a bite plate? _____

Have you had a head, neck or jaw injury? _____

Have you ever had oral surgery? _____

If you have had previous dental radiographs ("X-Rays"), can you obtain them? _____

Would you like to change anything about your smile? _____

_____

Is there anything else we should know to make your visits more comfortable? _____

_____

_____