Please Circle/Fill out form to aid us in your Periodontal Health Care at Sunshine Dental of Gulf Breeze, Thank you

Name_____ Preferred phone #_____

Address: _____

ARE YOU HAPPY WITH YOUR SMILE? Y N - IF NOT WHY _____

HAVE YOU HAD ORTHODONTIC? Y N HAVE YOUR TEETH RELAPSED? Y N

Do you have Allergies? Y N - Please list _____

Do you use Tobacco: Y N - If yes, how much per day _____

Do you require Antibiotic Pre-Med for cleanings? Y N - If yes, why?

_____

List all Medications including supplements _____

_____

Are you Gums hurting today? Y N Do you have a Tooth Ache today? Y N

Do you have Bad Breath? Y N Do you Grind or Clench your Teeth? Y N

Does your Jaw Pop/Click? Y N Do you Wear a Hard/Soft nightguard? Y N

Do you see Blood when: Flossing? Y N Brushing? Y N

Please list frequencies per day: Brushing: ____ /day Mouth rinsing: ____ /day

Flossing: ____ /day; traditional floss, floss pick, or water pik?

ARE THERE ANY CHANGES TO THE LAST FORM YOU FILLED OUT? Y N

WOULD YOU LIKE A COMPLIMENTARY BOTOX CONSULT w/Dr. RAK TODAY?

Please Notify Front Desk if you are: Pregnant, Diabetic, have Heart Disease or undergoing Chemo or Radiation Therapy. Guidelines for insurance may allow more than 2 cleaning a year.