Phone Numbers

Home	**Work**	**Cell**
Spouses Phone Number		**Best time to reach you**
Emergency Contact		**Phone**
Relationship to Patient		

Dental History

Reason for Today's Visit

Former Dentist	**Location**	**Date of last Dental visit**

Please circle all that apply:

- Bad Breath
- Bleeding Gums
- Blisters on lips or mouth
- Burning sensation on the tongue
- Chew on the side of mouth
- Clicking or popping jaw
- Dry mouths
- Finger nail biting
- Food collection between teeth
- Foreign objects
- Grinding teeth
- Gums swollen or tender
- Jaw pain
- Lip or cheek biting
- Loose or broken fillings
- Mouth breathing
- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitive to cold or heat
- Sensitive to Sweets
- Sensitive when biting
- Smoking
- Sores in mouth

How often do you floss? _____ How often do you brush?_____