CS FAMILY DENTISTRY
CLARKE SHORT FAMILY DENTISTRY

Dental & Oral Health Information

Do you have any specific dental problems or discomfort at this time?

_____

_____

Previous Dentist's Name: _____City & State: _____

Approximate date of your last dental exam, x-rays and cleaning: _____

Who referred you to our office? _____

Are you nervous about dental treatment? _____

How often do you Brush? _____

How often do you Floss? _____

Are you using an electric or regular toothbrush? _____

Do your gums bleed when you brush? _____If yes, Describe: _____

Are your gums red, swollen, tender or sore? _____

Do you have gums that have pulled away from the teeth? _____

Do you clench or grind your teeth? _____

Do you have any clicking, popping or difficulty when chewing? _____

Do you have difficulty opening or moving your jaws? _____

Do you have loose or separating teeth? _____

Do you have any color changes of the tissues in your mouth? _____

Do you have pain, tenderness, numbness, or earaches? _____

Do you wear any removable dental appliances? _____

If yes, what type and for how long? _____

How do you feel about the appearance of your smile and what would you change if you could?

_____

Have you ever had any complications from an extraction or dental treatment? _____

If yes, please explain: _____

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth? _____

If yes, please explain: _____

Tobacco Questions

Smoking Status: (Circle One)

Never Previous Current

How much per day? _____

How long have you smoked? _____

Would you like to quit? _____

Chewing Status: (Circle One)

Never Previous Current

How much per day? _____

How long have you chewed? _____

Would you like to quit? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment without fail.

Signature: _____Date: _____