ALVAREZ DENTAL

Patient Name:_____ DOB: _____

Answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate to your particular needs. Your answers are for your records only and will be considered confidential.

Are you having any discomfort at this time? _____

Date of last dental visit: _____

Have you ever been treated for periodontal disease? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Your tooth brush is: (circle one) Soft Medium Hard

Are you concerned about the appearance of your teeth or mouth? _____

Are you interested in bleaching your teeth? _____

Do you have or have you ever had any problems with:

MOUTH

Bleeding/sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blister lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatment (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or Closing jaw	Yes	No

TEETH

Loose Teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No