jp dental
family cosmetic implant dentistry

Current Dental Health

Please check if any of the following problems apply to you:

[ ] Sensitivity
[ ] Tooth pain or discomfort when chewing
[ ] Headaches, ear aches, neck pain
[ ] Mouth ulcers or cold sores
[ ] Jaw joint pain
[ ] Broken tooth or fillings
[ ] Grinding or clenching teeth
[ ] Bleeding, swollen or irritated gums
[ ] Loose, tipped or shifted teeth
[ ] Bad breath or bad taste in your mouth

Do you or have you had any of the following?

[ ] Dentures
[ ] Par al dentures
[ ] Braces
[ ] Gum treatments
[ ] Implants
[ ] **Required to take an bio cs prior to dental treatment**

Do you smoke or use chewing tobacco? [ ] yes [ ] no

How much?__________________________For how long? ______________________________

If you could change your smile, you would:

[ ] Make my teeth whiter
[ ] Make my teeth straighter
[ ] Close spaces
[ ] Fix crowding
[ ] Replace metal fillings with tooth colored fillings
[ ] Repair chipped teeth
[ ] Replace missing teeth
[ ] Replace old crowns that don't match
[ ] Have a smile makeover

Please share the following dates:

Your last cleaning:______/_____/______
Your last oral cancer screening:______/_____/______
Your last set of complete x-rays:______/_____/______
Previous Dentist / Dental Office ____

What is the most important thing to you about your dental visit today?

____

What is the most important thing to you about your future smile and dental health?

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