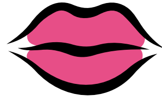 Miranda Lacy D.D.S., P.A.

DENTAL HEALTH

Patient Name: ___________________________ DOB:________ Date: ________

Reason for today's visit: _____________________ Currently in Pain? □ Yes □ No

Last Dental Visit: _____________ Reason for last dental visit:________________

Present / Previous Dentist: (name & location) ______________________________

How many times a day do you brush? ____ How many times a week do you floss? ____

CHECK ALL THAT APPLY

_____ Cleaned within the last year
_____ X-rays within the last year
_____ Teeth sensitive to hot or cold
_____ Teeth sensitive to sweet or sour
_____ Teeth sensitive to pressure
_____ Teeth feel loose
_____ Catching food between teeth
_____ Discomfort chewing
_____ Wisdom teeth removed
_____ Concerned about wisdom teeth
_____ Sore gums
_____ Bleeding gums
_____ Dry mouth
_____ Deep cleaning or gum treatments in the past
_____ Prolonged bleeding in past
_____ Sores, lumps in or near mouth
_____ Require antibiotics before treatment
_____ Wear denture or partial denture
_____ Unsatisfied with smile
_____ Interest in Invisalign or braces
_____ Interest in cosmetic dentistry
_____ Interest in whitening
_____ Interest in replacing missing teeth
_____ Interest in implants

_____ Clenching or grinding
_____ Have bite plate, nightguard, NTI
_____ Nightguard recommendation by dentist
_____ Difficulty opening or closing
_____ Head, neck, or jaw injury in past
_____ Experience pain/tenderness in jaw (TMJ)
_____ Joint pain, popping jaw
_____ Frequent headaches
_____ Interested in sports mouthguard
_____ Biting lips or cheeks
_____ Hard to get numb in past
_____ Bad reaction to Novocaine
_____ Difficult extractions in past
_____ Nervous about dental treatment
_____ Difficulty leaning back
_____ Choke/gag easily
_____ Would like laughing gas with cleaning
_____ Does not like laughing gas
_____ Interest in anti-snoring appliance
_____ Uses Electric Toothbrush
Brand:_____________________

Type of toothbrush:
___ Hard ___ Medium ___ Soft

_____ Uses mouth rinse
Type/Brand:_____________________