

DENTAL HISTORY INFORMATION

How may we help you today? _____

Your current dental health is: Good Fair Poor

Yes No

- Do you require antibiotics before dental treatment?
- Are you currently in pain?
- Have you ever had gum treatment?
- Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ)?
- Are you under stress (new job, moving, relationships)?
- Do you like your smile?
- Is there anything you would like to change about your smile?
- Are you happy with your teeth?
- Do your gums bleed?
How many times do you: floss per week? _____ brush per day? _____
- Are your teeth sensitive to heat, cold or anything else?
- Have you lost any teeth?
- Have you ever had a serious/difficult problem with any previous dental work?
- Have you ever had any unfavorable dental experiences?
When was your last dental cleaning? _____
When was your last dental visit? _____
Why did you leave your previous dentist? _____
How can we accommodate you better during your dental visits? _____

At Lancaster Smiles we offer a variety of services to help enhance and keep your smile beautiful.
Please circle any services below that you would like our friendly staff to discuss with you during your visit:

- | | |
|---------------------------------|-----------------|
| Bonding | Root Canals |
| Cosmetic Tooth Colored Fillings | Sealants |
| Crown and Bridge | Smile Makeover |
| Implant Crowns | Tooth Whitening |
| Night/Sport Guards | Veneers |
| Partials/Dentures | |