Dental Information

First Name: _____Last Name: _____

Reason for Today's visit:

Are you in pain ? Yes or NO

Please circle any of the following problems:

- Discomfort
- Clicking
- Popping or locking of jaw
- Lost/Broken fillings
- Stained Teeth
- Red, Swollen, or bleeding gums
- Teeth Grinding
- A removable dental appliance
- Ringing in ears
- Bad breath
- Loose/Shifting Teeth
- Blisters
- Broken/Chipped teeth
- Burning tongue/lips
- Gum Disease
- Prolonged bleeding from an injury
- Toothache
- Swelling/lumps in mouth
- Recent Infections
- Food Caught between teeth
- Other, please Explain:

Signature _____ Date _____