COOL SPRINGS FAMILY DENTISTRY, PLLC

@Moore's Lane

	Question	Yes	No
1.	Do your gums bleed while brushing or flossing?	◯	◯
2.	Are your teeth sensitive to hot/cold, liquids/foods?	◯	◯
3.	Are your teeth sensitive to sweet/sour, liquids/food?	◯	◯
4.	Do you feel pain to any of your teeth?	◯	◯
5.	Do you have any sores or lumps in or near your mouth?	◯	◯
6.	Have you ever experienced any of the following problems with your jaw?		
	Clicking	◯	◯
	Pain	◯	◯
	Difficulty in opening/closing	◯	◯
	Difficulty in chewing	◯	◯
7.	Have you ever had any head, neck or jaw injuries?	◯	◯
8.	Do you have frequent headaches?	◯	◯
9.	Do you clench or grind your teeth?	◯	◯
10.	Do you bite your lips/cheeks often?	◯	◯
11.	Have you ever had any difficult extractions in the pa:	◯	◯
12.	Have you ever had any prolonged bleeding from extractions?	◯	◯
13.	Have you had any orthodontic (braces) treatment?	◯	◯
14.	Do you wear dentures or partials?	◯	◯
15.	Have you received oral hygiene within the last 12 months?	◯	◯
16.	Do you like your smile?	◯	◯

Name of Previous Dentist ______________________________ Office Phone __________

Name of Physician ______________________________ Office Phone __________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accuratel I understand that providing incorrect information can be dangerous to my health and to my provider. I authorize the dentist to release any informat including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a thirc party health practitioner.

Patient Name ______________________________

Signature ______________________________ Date ____________

Doctor's Comments ______________________________

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