If you could change anything about your smile, what would it be? Do you have specific dental problems/concerns? Is: Do you have dental care on a regular basis? Yes No Is. When was your last dental examination and cleaning? Is: When did you have your last complete series of dental X-rays? How often do you brush your teeth? Have you been told you have gum disease? Yes No Have you been told you have gum disease? Yes No Have you been told you have gum disease? Yes No Do your gums bleed when you brush? Yes No Do your gums bleed when you brush? Yes No Do you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have halitosis or "bad breath"? Yes No It have you have problems with allergies to Any local anesthetic? Yes No Address Address Address It have you have problems with allergies to Any local anesthetic? Yes No Address Address	PATIENT NAME				DATE		
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	PATIENT OR PARENT/GUARDIAN SIGNATURE						

Medical History Updates

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