BROOKWOOD
DENTAL CARE

Dental History

Reason for Visit: _____

Date of Last Dental Visit: _____

Date of Last Dental X-rays: _____

How often do you floss? _____

How often do you brush? _____

Circle one:

Yes / No	Bad Breath
Yes / No	Bleeding, Red, Swollen Gums
Yes / No	Broken/Loose Teeth or Fillings
Yes / No	Clicking or Popping of Jaw
Yes / No	Grinding Teeth
Yes / No	Pain Around Ear/Side of Face
Yes / No	Sore/Blisters in Mouth

List any other dental concerns/pain

Signature* Date*

_____ _____

_____ _____