Gentle Dental Spa

Cosmetic and Family Dentistry
Dr. Thomas M. Pham, DMD
Dr. Justine A. Turla, DMD

Dental History

1. Do your gums bleed while brushing or flossing?	___Yes ___ No
2. Are your teeth sensitive to hot or cold liquids/foods?	___Yes ___ No
3. Are your teeth sensitive to sweet or sour liquids/foods?	___Yes ___ No
4. Do you feel pain in any of your teeth?	___Yes ___ No
5. Do you have any sores or lumps in or near your mouth?	___Yes ___ No
6. Have you had any head, neck or jaw injuries?	___Yes ___ No
7. Have you ever experienced any of the following problems in your jaw?	
a. Clicking?	___Yes ___ No
b. Pain (joint, ear, side of face)	___Yes ___ No
c. Difficulty in opening or closing	___Yes ___ No
d. Difficulty in chewing	___Yes ___ No
8. Do you have frequent headaches?	___Yes ___ No
9. Do you clench or grind your teeth?	___Yes ___ No
10. Do you ever bite your lips or cheeks frequently?	___Yes ___ No
11. Have you ever had any difficult extractions in the past?	___Yes ___ No
12. Have you ever had any prolonged bleeding following extractions?	___Yes ___ No
13. Have you ever had orthodontic treatment?	___Yes ___ No
14. Do you wear dentures or partials?	___Yes ___ No
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	___Yes ___ No
16. Do you like your smile?	___Yes ___ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in dental status.

Patient Signature: _____ Date: _____