PAUL B. TAN, D.M.D.
GENERAL & COSMETIC DENTISTRY
• EST. 1989 •

Dental History

Date of last dental visit:_____ Last cleaning:_____

Reason for today's visit:_____ How often do you:
Brush: _____
_____ Floss: _____

Do you have or have you ever had:

- ☐ Orthodontic treatment?
- ☐ Missing teeth that you want replaced?
- ☐ Food catching between your teeth? Where? _____
- ☐ Bad breath?
- ☐ Gums that bleed when you brush or floss?
- ☐ Been told you have gum problems?
- ☐ Clench or grind your teeth during the day or at night?
- ☐ Wake up with sore jaw muscles?
- ☐ Have frequent headaches?
- ☐ Ever have pain in your jaw joint (around your ear)?
- ☐ Clicking or popping of jaw joint?
- ☐ An inability to open your mouth?
- ☐ A concern or fear of dental treatment?

Sensitivity to:

- ☐ Chewing Where? _____
- ☐ Hot or cold Where? _____
- ☐ Sweets Where? _____

Smile Evaluation:

Are you happy with the appearance of your teeth? _____

If you could make changes in your teeth what would they be?

- ☐ Color? _____
- ☐ Shape? _____
- ☐ Position? _____

Do you dislike the color of your old fillings? _____

Would you like to know more about how to enhance your smile?_____

What can we do to give you the best possible dental experience? _____

_____

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