Patient Dental Health

NAME: ______________________________________ Pharmacy: _________________________________

When was the Last time you have seen a Dentist: ______________ Last cleaning: ____________________

Are you currently in pain? _____ For how long? _____________ Pain level 1-10, 10 being the highest: _____

Are you taking anything for pain? How much and how often? _______________________________________

Explain Pain: (sharp/throbbing/dull ache) ____

Any teeth broken, have holes or are loose? ______________ Where? (ie: Back upper left) _______________

Do you require antibiotics before dental treatment? If so, what? _____________________________________

Do you use tobacco: _________ Vape: __________ Recreational Drugs: _________ Marijuana: ________

Medication: ____

Does anyone in your family have oral cancer? □ Yes □ No

Are you interested in teeth whitening? □ Yes □ No Invisalign® teeth straightening? □ Yes □ No

Oral Health: Use this checklist as a guide and mark ALL that apply to you today.

□	anxiety/fearful/feeling scared	□	loose tooth/teeth
□	bad breath/halitosis	□	lump
□	bleeding in your mouth	□	receding gums
□	blisters/sores/lesions	□	sensitivity (i.e. hot/cold)
□	coating on the tongue	□	sinus pain
□	dry mouth/sticky feeling in mouth	□	soreness/tenderness
□	infection/pus	□	swelling/inflammation
□	injury/trauma	□	taste/change in or loss of
□	jaw joint pain/popping/pressure	□	Throbbing or dull ache

Standard Infection Control: **Use this checklist as a guide and mark ALL that apply to you today**.

□	Flu-Like Symptoms	□	Recent trips out of the United States
□	Recent Blood transfusion	□	Recurring fevers
□	Frequent, forceful coughing	□	Open skin sores, abrasions

DATE: ______________________