Stephen A Mabry, DDS
Ann G Kemps, DMD

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Patient Dental History

1. Date of Last Dental Visit: _____ Reason for Last Dental Visit: _____

2. Date of Last Dental Cleaning: _____ Date of Last Dental X-rays: _____

4. Do you have any concerns about or complications from previous dental care?_____

_____

Please circle your response for the following questions.

5. Do you have dental anxiety? **Yes** **No**

6. Do your gums bleed? **Yes** **No**

7. Have you been told you have gum disease? **Yes** **No**

8. Are your teeth sensitive? **Yes No**

Circle all that apply: **Hot** **Cold** **Sweets** **Pressure**

9. Do you or have you been told you clench or grind your teeth? **Yes** **No**

10. Do you or have you had any pain in your jaw joints (locking, clicking, popping)? **Yes** **No**

If yes, do you have a night guard? **Yes** **No**

11. Do you snore or have sleep apnea? **Yes** **No**

12. Have you had braces or orthodontic treatment? **Yes** **No**

13. Have you whitened your teeth? **Yes** **No**

14. Are you happy with the appearance of your smile? **Yes** **No**

If no, please explain: _____

15. Are there any concerns you would like to discuss with Dr. Mabry or Dr. Kemps? **Yes** **No**

If yes, please explain: _____

To the best of my knowledge, the answers I have given are truthful and accurate. I understand the importance to disclose any changes or updates in my medical and dental status.

Print Patient Name_____

Patient Signature_____Date _____

If you have completed this form for another person, please complete and sign below:

Print_____ Relationship_____

Signature _____Date _____