NEW PATIENT GENERAL DENTAL INFORMATION

Have you ever had any serious or unusual instances with any previous dental treatment, including local anesthesia (local anesthesia, nitrous oxide, and/or other medications may be used during your dental visit unless indicated)?
Explain:____
____

Have you ever had an unpleasant experience in a dental office? ______________________________
Explain:____
____

Have you or either of your natural parents ever had gum disease, pyorrhea, early tooth loss, or any other oral conditions? ____
Explain:____
____

Are your teeth sensitive to hot or cold? ____

Do your gums bleed when you brush or floss? ____

Have your teeth shifted or moved, or any teeth loose? _______________________________________

Do you experience any jaw pain, tooth clenching or night grinding? ___________________________
If so, do you wear an appliance? ____

How often do you brush? ____

What type of toothpaste do you use? Baking Soda Tarter Control Whitening Other ______________

What type of toothbrush do you use? Hard Medium Soft Extra Soft Electric ______________

What other oral hygiene aids do you use? Floss Mouthwash Waterpik/Oral Irrigator Other ___________

What would like to change about your smile (appearance, health and function)?
____
____

Tell us about any other dental concerns you have?
____
____

By signing below, I certify that I understand this General Dental Information Form and the importance of its accuracy. I have answered the questions to the best of my knowledge and will not hold Johnson & Montoya Dental, P. C. responsible for any errors or omissions I may have made in completing it.

Signature: ____ **Date:**________________

(Parent or Legal Guardian if Under 18 Years of Age)