

Stewart Dental *the Smile Shoppe*

Dental History

When was your last dental visit? ____ Months ____ years

Reason for leaving last dentist? _____

When was your last dental cleaning? ____ Months ____ years

How often do you brush your teeth? _____ Times per day

How often do you floss? ____ Day ____ week ____ month ____ rarely

Does it tear when you floss? Yes No

Do you have any broken teeth? Yes No

Do you use any tobacco products? Yes No

Have you ever had braces? Yes No If yes, when? _____

Have you had your wisdom teeth out? Yes No If yes, when? _____

How old are you? _____

Do your gums bleed when you brush or floss? Yes No

Do you get food packed between your teeth? Yes No

Do you grind your teeth? Yes No

Do you snore? Yes No

Do you have sensitive teeth? Yes No

Do you have any discomfort? Yes No

Would you like fresher breath? Yes No

If you could change your smile what would you like to do? _____

Do you have any concerns not mentioned? _____

Thank you for choosing
Stewart Dental