Dr. Lawrence Busch

DENTAL HISTORY

Patient Name____ Date______________________

Please Circle

Do you have a specific dental problem? Yes No
Describe ____

Do you have dental examinations on a routine basis? Yes No
Last Visit ____

Do you think you have active decay or gum disease? Yes No

Do you brush and floss on a routine basis? Yes No
Discuss____

Do your gums ever bleed?
Discuss____ Yes No

Do you like your smile? Yes No
Why?____

Does food catch between your teeth? Any loose teeth? Yes No

Do you want to keep your remaining teeth? Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Yes No

Do you clench or grind teeth? Yes No

Have your past experiences in a dental office always been positive? Yes No

Do you smoke or chew? Any sores or growths in your mouth? Yes No
Discuss ____
Do you use e-cigarettes or vaping products? Yes No

Do you snore? Yes No

Names of previous dentist (Optional):____

Date of last full mouth x-rays (16 small films or panoramic):
____