GUMS & SMILES FAMILY DENTAL

Patient Name: _____ Date:_____

Reason for your visit today: _____

Last dental visit place & Date: _____

How did you hear about us?

- ☐ Insurance Company
- ☐ Google
- ☐ Facebook
- ☐ Drive/Walk by
- ☐ EDDM/Mailer
- ☐ Staff
- ☐ Patient/Friend/Dentist Referral : _____
- ☐ Other _____

PATIENT DENTAL HISTORY

	YES	NO
Do you require antibiotics before dental treatment?	☐	☐
Are you currently in pain?	☐	☐
Do your gums bleed?	☐	☐
Have you ever had a serious problem associated with any previous dental work?	☐	☐
Do you now or have you experienced pain in your jaw joint?	☐	☐
Have you ever had periodontal diseases?	☐	☐

How many time a day do you brush? _____

Do you floss? How many time a week? _____

Types of bristles? Hard ☐ Medium ☐ Soft ☐