SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ Date: _____
Last First

Date of Birth: _____ Age: _____

Name of Dentist: _____

Who may we thank for referring you to this office? _____

Pharmacy: _____

DENTAL HISTORY

What is the reason for today's visit? How did your dentist explain why you are seeing us?

Date of most recent dental vist?

How often do you see your dentist?

On a scale of 1 (least) to 10 (most) how fearful or anxious does dental treatment make you?

Tell us about any previous bad dental experiences or important dental information.

Does anything bother you about the appearence of your teeth? (Color, Shape, Position, etc.)

Do you have any problems with jaw joint or facial muscle pain/abnormal senstations? Any popping or clicking?
Have you ever worn a bite guard?

Any other important details about your dental history we may have forgotten to ask about?

Do your gums bleed when you floss or brush? ☐ **Y** ☐ **N**

Are your teeth sensitive to hot, cold, sweets, or pressure? ☐ **Y** ☐ **N**

Have you had any periodontal (gum) treatments before? ☐ **Y** ☐ **N**

Do you grind or clench your teeth? ☐ **Y** ☐ **N**

Is there a history of periodontal disease or missing teeth in your family? If so, who?