Zora & Hanko
Doctor of Dental Medicine
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Dental Information

Date of your last dental exam: _____
What was done at that time? _____
Date of last dental x-rays: _____
What is the reason for your dental visit today? _____
How do you feel about your smile? _____
How often do you brush? _____
How often do you floss? _____

YES NO *For the following questions, please mark (X) for your responses*

☐ ☐ Do your gums bleed when you brush or floss?
☐ ☐ Are your teeth sensitive to: cold / hot / sweets / pressure (circle any that apply)
☐ ☐ Do you drink: soda / diet soda / tea / juices / coffee (circle any that apply)
☐ ☐ Do you feel that you have a dry mouth?
☐ ☐ Have you had any periodontal (gum) treatments?
☐ ☐ Have you ever had (braces) orthodontic treatment?
☐ ☐ Have you had any problems associated with previous dental treatment?
☐ ☐ Is your home water supply fluoridated?
☐ ☐ Do you drink bottled or filtered water?
☐ ☐ Are you currently experiencing dental pain or discomfort?
☐ ☐ Do you have earaches or neck pain?
☐ ☐ Do you have any clicking, popping, or discomfort in the jaw?
☐ ☐ Do you brux or grind your teeth?
☐ ☐ Do you have sores or ulcers in your mouth?
☐ ☐ Do you wear dentures or partials?
☐ ☐ Do you participate in active recreational activities?
☐ ☐ Have you ever had a serious injury to your head or mouth?
☐ ☐ Is there any other pertinent dental information you would like to share or explain? _____

NOTES: _____

Medical Information

YES NO *For the following questions, please mark (X) for your responses*

☐ ☐ Are you under the care of a physician? Physician Name: _____
Street: _____ Physician Phone: _____
City _____ State _____ Zip _____

☐ ☐ Are you in good health?
☐ ☐ Are you pregnant?
☐ ☐ Has there been any change in your general health within the past year?
If yes, what condition is being treated? _____
Date of last physical exam: _____
☐ ☐ Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem? _____