Crow River Dental
Big Smiles!

Dental History

Please check the reason why you are here today?

☐ Emergency Visit ☐ First Examination ☐ Consultation

Where and when was your last dental visit?

Date of last X-Rays taken: ____ /____ /________

Please check any of the concerns or problems you are aware of:

☐ Sensitive to Hot
☐ Sensitive to Sweets
☐ Jaw Pain
☐ Food Impaction
☐ Loose Teeth
☐ Sensitive to Cold
☐ Sensitive to Chewing
☐ Jaw Click/Snap
☐ Chipped Teeth
☐ Sensitive to Brushing
☐ Bleeding/Hurting Gums
☐ Clench/Grind
☐ Dental Pain

Or any other dental concerns we need to know about?

Have you ever had any of the following:

☐ Complications with dental treatment
☐ Gum Treatments (scaling and root planing)
☐ Braces (Orthodontic Treatment)

Are you happy with the way your teeth look now?

☐ Yes ☐ No

If NO, explain:

Response Date: ____ /____ /________