CROSBY
FAMILY DENTISTRY

Dental Information

First Name _____ Last Name _____

Reason for visit: _____

_____

_____

Are you in pain?

☐ Yes ☐ No

Please indicate any of the following problems by selecting the corresponding boxes:

☐ Toothache	☐ Lost/broken filling(s)	☐ Broken/chipped tooth	☐ Difficulty opening jaw
☐ Red, swollen, or bleeding gums	☐ Teeth grinding/ clenching	☐ Chewing Sensitiviy	☐ Hot/Cold Sensitivity
☐ A removable dental appliance	☐ Food caught between teeth	☐ Swelling/lumps in mouth	☐ Loose / shifting teeth
☐ Snoring/Sleep Apnea	☐ Appearance of smile	☐ Bad Breathe	☐ Dental anxiety

☐ Other

If other, please explain: _____

_____

_____

_____

Is there anything else that would be helpful for your dentist to know? ☐ Yes ☐ No

_____

_____

_____

_____