DENTAL HISTORY

Your Name: ______________________________________

Please check any of the following problems that may apply:

____	Sensitivity to: (Hot, Cold, Sweets)	____	Grinding or Clenching Teeth
____	Headaches, Ear Aches, Neck Pain	____	Bleeding, Swollen or Irritated Gums
____	Jaw Joint Pain	____	Loose, Tipped or Shifting Teeth
____	Broken Teeth or Fillings	____	Bad Breath or Bad Taste in your Mouth

Do you have or have you had any of the following:

____ Dentures ____ Partial Dentures ____ Braces ____ Periodontal *(Gum)* Treatments

When was your last dental cleaning and exam? Why did you leave your previous dentist?

Month Year

____________ ____________ ______________________________

We strive to improve communication with our patients.
We will contact you just prior to your scheduled appointment.

What Appointment reminder method would you prefer?

Text Message: *Yes No (circle one)*

OR

Phone Call: (Circle One) *Home? Cell? Work?*

How did you hear about Dr. Tucker? ______________________________________

If you were referred, whom may we thank for this referral? __________________________