UDA
University Dental Associates
Modern Dentistry with a Gentle Touch

Patient Information • Dental History

Reason for Visit____

____

Please check appropriate box

Have you lost teeth or had any removed Yes ( ) No ( )

Have they been replaced Yes ( ) No ( )

Are you unhappy with the replacement Yes ( ) No ( )

If yes, please explain____

____

Have you had previous dental complications Yes ( ) No ( )

If yes, please explain____

____

Do you grind your teeth Yes ( ) No ( ) Do your gums bleed or hurt Yes ( ) No ( )

Are your teeth sensitive to Hot ( ) Cold ( ) Sweets ( ) Pressure ( )

How often do you brush_______________________________Do you use dental floss Yes ( ) No ( )

If yes, how often______________________

Are your teeth loose, tilted, shifted, or chipped Yes ( ) No ( ) Do you like your teeth Yes ( ) No ( )

Have you ever had gum treatment or surgery Yes ( ) No ( ) If yes, when__________________________________

Do you think dental implants are right for you Yes ( ) No ( )

Signature____Date______________