770.992.6568
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SHENK DENTAL CARE

Judd W. Shenk, DMD

Dental History

Are you in dental discomfort? _____

Reason for visit today _____

Date of last dental care ___/___/_____ Date of last X-ray ___/___/_____

Former dentist _____

Have you had any unfavorable dental experiences? _____

Check if you have had problems with any of the following:

__ Bad Breath	__ Food collection between teeth	__ Periodontal treatment
__ Bleeding gums	__ Grinding or clenching teeth	__ Sensitivity to cold
__ Clicking or popping jaw	__ Loose teeth or broken fillings	__ Sensitivity to hot
__ Sensitivity to sweets	__ Sensitivity when biting	__ Sores or growths in mouth

How often do you brush? _____
How often do you floss? _____
Have you ever had instruction on the correct method of brushing teeth? __ Yes __ No
Have you ever had instruction on the care of your gums? __ Yes __ No

How do you feel about the appearance of your teeth and smile?
_____

What would you like to change? _____