Date of Last X-Reys	City, State	ng
Date of Last Dental Visit	Date of Last Dental Visit	ng
Please check all that apply: Bisder Peath	Please check all that apply: Bad Breath	ıg
Bed Breding Gums Criticodontic Treatment Sensitivity to Sweets Sensitivity to Coll Sensitivity to Sweets Sensitivity to Coll S	Bad Breath	ng
Blisters on Lips or Mouth Pain Around Ear Pa	Bleeding Gums	ng
Bilsters on Lips or Mouth	Blisters on Lips or Mouth	-
Periodontal Treatment Jaw. Head or Nock Injuries Jaw Difficulty: Clicking and/or Pain. Jaw Difficulty: Clicking and/or Pain. Jaw Difficulty: Clicking and/or Pain. Tooth Pain	Finger Nail Biting	
Sensitivity to Cold Sensitivity to Cold Sensitivity to Heat Tooth Pain Tooth Pain Sensitivity to Heat Sensitivity to Heat Tooth Pain	Grinding Teeth	ıries
Medical History	Sensitivity to Heat	
Are you under a physician's care now? Yes No If yes, please explain: e you ever been hospitalized or had a major operation? Yes No If yes, please explain: Have you sever had a serious fised or neck injury? Yes No If yes, please explain: Are you taken, Phen-Fen or Reduct? Yes No No If yes, please explain: Do you take, or have you taken, Phen-Fen or Reduct? Yes No Do you use tobacco? Yes No No No No Yes No Do you use tobacco? Yes No No No No Yes No No Do you use tobacco? Yes No No No Yes No No No Yes No No Do you have, or have you had, any of the following? Shrill Yes, please explain: Output No	Medical History Are you under a physician's care now? O Yes O No If yes, please explain:	and/or Pain.
Are you under a physician's care now?	Are you under a physician's care now? O Yes O No If yes, please explain:	***************************************
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