

Dental Remedies

135 Jenkins St. Ste. 105A

St. Augustine, FL 32086

Dental Information

How would you rate the condition of your mouth?

- Excellent
- Good
- Fair
- Poor

I routinely see my dentist every:

- 3 months
- 4 months
- 6 months
- 12 months
- Not Routinely

What is your immediate concern? _____

If you could change your smile, you would:

- Make it brighter
- Replace old crowns that don't match
- Close spaces
- Make it straighter
- Repair chipped teeth
- Replace missing teeth

Are you interested in whiter teeth?

- Yes
- No

Check all that apply:

- Had any reactions to local anesthetic
- You clench or grind your teeth
- Any teeth sensitive to hot, cold ,biting ,sweets or avoid brushing any part of your mouth
- You have difficulty chewing
- Gums bleed when brushing/ flossing

- Treated for gum disease or were told you have lost bone around your teeth
- Noticed an unpleasant taste or odor in your mouth
- Headaches, earaches, neck pain
- Jaw Joint pain (TMJ)

If any of the boxes need further explanation, please describe:

Signature: _____ Date: _____