GLASGOW DENTAL CARE
Drs. Thurman & Cassady

Dental History

What is your primary reason for seeking dental care today? (Ex: check-up, pain, dental concerns, other)
_____

What is the month/year of your last dental visit? _____

How often do you visit the dentist? _____

☐ Yes ☐ No Are your teeth sensitive to hot/cold/pressure/sweets?

☐ Yes ☐ No Do your gums feel tender and/or bleed?

☐ Yes ☐ No Have you had periodontal (gum) treatment?

☐ Yes ☐ No Do you have a dry mouth?

☐ Yes ☐ No Do you experience acid reflux, especially at night?

☐ Yes ☐ No Do you have bad breath or a bad taste in your mouth?

☐ Yes ☐ No Does food catch between your teeth?

☐ Yes ☐ No Do you have problems with teeth/fillings breaking?

☐ Yes ☐ No Do you clench or grind your teeth?

☐ Yes ☐ No Do you have tired jaws especially in the morning?

☐ Yes ☐ No Are you unhappy with the appearance of your teeth?

☐ Yes ☐ No Are you interested in whitening your teeth?

☐ Yes ☐ No Are you interested in replacing any missing teeth?

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What types of beverages do you typically drink between meals?_____

HIPAA Acknowledgment

I acknowledge that I have received or read a copy of the Notice of Privacy Practices (HIPAA form). You may either request a copy or see the form in the reception area and on our website at www.drthurman.com.

Signature of Patient, Parent, or Guardian_____ Date_____