Patient Name: _____

Date: / /

Clark F. Brown, Jr. DDS, PA
2113 Sarno Road, Melbourne, FL 32935

DENTAL HISTORY

Previous or Current Dentist

Do you want us to be your primary dentist? Yes No

If not, will you maintain regular check-ups and cleanings with your current dentist? Yes No

Previous or Current Dentist's Name: _____

Dentist's Address: _____

City: _____ State: _____ ZIP: _____

Dentist's Phone: _____ Date of your last visit: / /

DENTAL CONCERNS

Are you currently in pain? Yes No If yes, describe: _____

What dental treatment(s) are you seeking? _____

DENTAL HISTORY

Do your gums bleed?	Yes	No	How many times a day do you brush?		
Are your teeth sensitive?	Yes	No	What type of tooth brush do you use?		
Do you wear dentures?	Yes	No	How often do you floss?		
Do you have TMJ problems?	Yes	No	Are you happy with your smile?	Yes	No
Have you had braces?	Yes	No	Do you want to avoid losing your teeth?	Yes	No
Have you had root canals?	Yes	No	Have you been treated for gum disease?	Yes	No

Describe any bad dental experiences you have had. _____