Cameron G. Francis Dentistry
2410 West University Dr.
McKinney, TX 75071

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____

PLEASE ANSWER "Y" OR "N" IF YOU HAVE/HAD ANY OF THE FOLLWING

1. Bad breathe?
2. Bleeding gums?
3. Blisters on lips or mouth?
4. Chew on one side of mouth?
5. Cigarette, pipe, or cigar smoking?
6. Clicking or popping jaw?
7. Dry mouth?
8. Fingernail biting?
9. Food collecting between teeth?
10. Grinding of teeth?
11. Gums swollen or tender?
12. Jaw pain or discomfort?
13. Loose teeth or broken filling?
14. Mouth breathing?
15. Do you snore or have sleep apnea?
16. Sensitivity to cold, hot, sweets, biting?
17. Do you have any missing teeth?
18. Are you happy with your smile?
19. Is there anything you would like to change about your smile?