TimLoughranDentistry
ADVANCED COSMETIC + FAMILY CARE

PATIENT DENTAL HISTORY

Your Name: ______________________________ Date: ______________

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would change about your smile? ______________________________

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Do your gums bleed? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental visit? ______________________________

How can we accommodate you best during your dental visit? ______________________________

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Here at Tim Loughran Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening   Veneers/Lumineers   Bonding

Smile Makeover   Crown and Bridge   Implants   Denture Services