Millard Roth, DDS

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DENTAL HEALTH INFORMATION

Previous Dentist: ___________________________ Date of Last Dental Visit: _________________

What is the reason for this visit? ____

Are you currently experiencing any tooth pain or sensitivity? Yes ◯ No ◯

- If yes what area and for how long? ____
- Hot ◯ Cold ◯ Chewing ◯

Is there anything about your smile you do not like? Yes ◯ No ◯

- If yes what would you like to change? ____

Do you have any fillings or dental treatment that you are unhappy with? Yes ◯ No ◯

- If yes what area? ____

Is your bite comfortable when chewing, biting? Yes ◯ No ◯

Do your gums bleed regularly? Yes ◯ No ◯

Do you have frequent headaches? Yes ◯ No ◯

Are you interested in Invisalign or Orthodontic Treatment? Yes ◯ No ◯

Is there anything else that you would like us to know? __________________________________