

Please Indicate An Answer For Each of the Following Questions:

Grind Teeth:	No	Possible	Present	Past
Bite Cheeks:	No	Possible	Present	Past
Tongue Thrust:	No	Possible	Present	Past
Mouth Breather:	No	Possible	Present	Past
Eating Disorder:	No	Possible	Present	Past
Thumb Sucking:	No	Possible	Present	Past
Toothpicks:	No	Frequently	Occasional	Past
Chewing Gum:	No	Frequently	Occasional	Past
Candy:	No	Frequently	Occasional	Past
Soft Drinks:	No	Frequently	Occasional	Past
Cigar/Cigarette:	No	Frequently	Occasional	Past
Pipe:	No	Frequently	Occasional	Past
Chewing Tobacco:	No	Frequently	Occasional	Past
Nail Biting	No	Frequently	Occasional	Past
Other Habits:	_____			

Please Circle Yes or No For Each History Question:

*Are Your Teeth Sensitive To:*

Hot/Cold:	No	Yes
Biting/Chewing:	No	Yes
Sweets:	No	Yes

*Have you Ever Had:*

Orthodontic Treatment:	No	Present	Past
A Bite Plate/Guard:	No	Present	Past
Periodontal Treatment:	No	Yes	
Oral Surgery:	No	Yes	
Serious Injury to Mouth or Head:	No	Yes	

**FOR OFFICE USE ONLY:**

#	Existing	Proposed	#	Existing	Proposed
1			17		
2			18		
3			19		
4			20		
5			21		
6			22		
7			23		
8			24		
9			25		
10			26		
11			27		
12			28		
13			29		
14			30		
15			31		
16			32		

Coments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_