Maria Jacome DDS PC
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(914) 686-1624

Your Dental History

What is the reason for your dental visit today? _____

Have you had any complications due to dental treatments?	Yes No
Do you have a high level of anxiety toward dental treatment?	Yes No
Do you have existing dental work?	Yes No
Have you ever had problems with local anesthetic?	Yes No
Have you ever been diagnosed with gum disease?	Yes No
Do your gums bleed while brushing, flossing, or on their own?	Yes No
Are any of your teeth loose?	Yes No
Are any of your teeth sensitive to hot or cold?	Yes No
Are you currently having any tooth or jaw pains?	Yes No
Do you have frequent headaches, earaches or neck pain?	Yes No

Have you had braces?
Yes No

Are you happy with your smile?	Yes No
Would you like straighter teeth?	Yes No
Are you happy with the color of your teeth?	Yes No
Are you interested in cosmetic dentistry?	Yes No
Have you ever had TMJ treatment for your jaw?	Yes No
Have you ever had your wisdom teeth removed?	Yes No

Please list what would you like to change about your smile:

_____
_____
_____

Please tell us any other concerns about your dental treatment:

_____
_____

_____