

14. Prior to this appointment, has root canal therapy been initiated on this tooth?

Yes No

Have you ever had a root canal done before?

Yes

No

If yes, how was the experience? _____

Who is your dentist? _____

1. How long has it been since your last cleaning? _____

2. Have you lost any teeth in the last year?

Yes

No

If yes, why? _____

3. Have you ever had orthodontic treatment (braces)?

Yes

No

4. Have you ever been treated for gum disease?

Yes

No

If yes: why and when? _____

5. Do you have any lumps in or near your mouth?

Yes

No

6. Have you had any head, neck, jaw, or teeth injuries?

Yes

No

7. Do you suffer anxiety before or during dental visits?

Yes

No

8. Have you ever been sedated for dental treatment?

Yes

No

9. Do you grind your teeth?

Yes

No

10. Do you wear a night guard?

Yes

No

Is there anything else we should know about you teeth, gums or sinuses?

Is there anything you would like to tell us, to make your experience more comfortable?

Signature: _____

Date: _____

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