Paul J. Kramer & James K. Kramer

www.drjameskramer.com info@kramerdmd.com

13 S. Main Street | P.O. Box 348 • Selbyville, DE 19975 (302)436-5133

Welcome to the Practice of
PAUL J. KRAMER, D.M.D. & JAMES K. KRAMER, D.M.D., P.A.

Dental History Form

1. What is the reason for your visit today? _____

2. When was the last time you saw a Dentist? What was done at that time? _____

3. Have you enter been treated for periodontal disease (gum disease)? ◯ Yes ◯ No

4. Have you had orthodontic treatment (braces)? ◯ Yes ◯ No

5. Do you snore? ◯ Yes ◯ No

6. Does Dental treatment make you nervous? ◯ Yes ◯ No

7. Have you ever had an unpleasant dental experience?
If yes, explain: _____ ◯ Yes ◯ No

8. Do you experience any of the following?

☐ Bleeding or sore gums	☐ Bad breath/unpleasant taste	☐ Frequent dry mouth	☐ Tingling or burning toungue or lips
☐ Swelling or lumps in mouth	☐ Sores in mouth	☐ Food trapping between teeth	☐ Loose teeth
☐ Sensitive to hot	☐ Sensitive to cold	☐ Sensitive to sweets	☐ Clicking/popping jaw
☐ Frequent headaches	☐ Grinding/clenching		

9. How often do you brush your teeth and do you use dental floss?
How often?_____ ◯ Yes ◯ No

10. What type of toothbrush do you use

☐ Soft ☐ Medium ☐ Hard ☐ Electric

Smile Evaluation

What other cleaning aids, devices, or rinses do you use? _____

1. Are you self conscious when you smile in front of other people or pictures? ◯ Yes ◯ No

2. Do you ever cover your smile with your hand? ◯ Yes ◯ No

Do you wish your teeth were whiter? ◯ Yes ◯ No

4. Do you dislike the shape of your teeth? ◯ Yes ◯ No

5. Do you have spaces between your teeth that you don't like? ◯ Yes ◯ No

6. Do you have old fillings or dental work that you don't like looking at? ◯ Yes ◯ No

7. If you could wave a "magic wand" and change the appearance of your smile, how would you like to look? _____

Please list any questions and concerns that you may have about your mouth or oral health:

_____

_____

Signature _____ **Date** _____