Tammy M. Boudry, D.D.S.
Boudry Dental LLC
10 Forest Ave., Suite 201 (920) 933-1310
Fond Du Lac, WI 54935

Name: _____Birth Date_____
First Middle Last

Dental Information

1. When was your last dental visit? _____
2. When were your last dental x-rays taken? _____
3. Do you have any areas of concern or sensitivity? If yes, please explain.
   _____
4. Have you had past orthodontic treatment? **Yes** **No**
5. Have you had your wisdom teeth removed? **Yes** **No**
6. Do you have reoccurring canker sores or cold sores? **Yes** **No**
7. Do you have lumps or sores (lesions) in your mouth now? **Yes** **No**
8. Have you ever been treated for gum or periodontal disease? **Yes** **No**
9. Do you experience dry mouth? **Yes** **No**
10. Do your teeth feel sore when you bite on them? **Yes** **No**
11. Do you clench or grind your teeth? **Yes** **No**
12. Does your jaw click or pop? **Yes** **No**
13. Are you unhappy with the appearance of your teeth? **Yes** **No**
14. Are you interested in whitening? **Yes** **No**
15. Do hot, cold or sweet beverages cause discomfort/pain in your mouth? **Yes** **No**
16. What are your feelings regarding fluoride? _____

SIGNATURE: _____DATE: _____