

Welcome!

So that we may provide you with the best possible care, please be sure to answer every question on this form.

PATIENT NAME: _____ Phone#: _____
 (First) (Middle) (Last)

What is the primary reason or concern that made you think of calling us?

Is there something in particular that you would like us to focus on for you? _____

PLEASE PROVIDE US WITH THE FOLLOWING IMPORTANT DATES (IF POSSIBLE):

Date of Last Dental Visit: _____ What did you have done? _____	Last x-rays taken: Bitewings: _____ Full mouth series: _____ Panographic (full smile): _____
Last Dental "Cleaning": _____ - OR - Last periodontal treatment: _____	
How often do you have dental examinations? _____	How often do you brush your teeth?: _____
How often do you floss? _____ If not often, or not at all, why? _____	What other types of dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Please provide your previous dentist's name, address & phone #, so that we may contact that office if need arises:

(Name)

(Address)

(Phone)

ARE ANY OF YOUR TEETH SENSITIVE TO:			HAVE YOU EVER HAD:		
Hot or cold?	Yes	No	Orthodontic treatment?	Yes	No
Sweets?	Yes	No	Oral Surgery?	Yes	No
Biting or Chewing?	Yes	No	Periodontal treatment?	Yes	No
ARE YOU BOTHERED BY:			Your teeth ground or bite adjusted?		
Frequent cold sores, blisters or any other oral lesions?	Yes	No	A bite plate or mouth guard?	Yes	No
Any mouth odors or bad tastes?	Yes	No	A serious injury to the mouth or head? If "yes", please provide details: _____	Yes	No
Loose or clicking partial, bridge or denture?	Yes	No			
DO YOUR GUMS BLEED OR HURT?			HAVE YOU EVER EXPERIENCED:		
Have your parents experienced gum disease or tooth loss?	Yes	No	Clicking or popping of the jaw?	Yes	No
Have you noticed any loose teeth?	Yes	No	Pain? (joint, ear, side of face)	Yes	No
Have you noticed any change in how your teeth fit together?	Yes	No	Difficulty opening or closing your mouth?	Yes	No
Does food tend to get caught between your teeth? If "yes", where? _____	Yes	No	Difficulty chewing on either side of your mouth?	Yes	No
			Headaches, neck aches or shoulder aches?	Yes	No
			Sore muscles (neck, shoulders)?	Yes	No
DO YOU:			ARE YOU SATISFIED WITH HOW YOUR TEETH LOOK?		
Clench or grind your teeth while awake or asleep?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Do you feel nervous about having dental treatment? If "yes", what are your biggest concerns? _____	Yes	No
Hold foreign objects with your teeth? (pencils, pins, paperclips, pipe, etc.)	Yes	No			
Breathe through your mouth while awake or asleep?	Yes	No	Have you ever had an upsetting experience at a dental office? If "yes", please describe: _____	Yes	No
Have tired jaws, especially in the morning?	Yes	No			
Snore or have any other sleeping disorders?	Yes	No			
Smoke/chew tobacco or use other tobacco products?	Yes	No	Are you the type of patient who feels more comfortable having the doctor or dental assistant tell you about what is being done during your treatment?	Yes	No