

PATIENT NAME:

Previous Dentist:

Your last dental x-rays?

What is the reason for this dental appointment? _____

Have you lost any of your natural teeth? YES NO

Have they been replaced? YES NO

If yes, how have they been replaced? _____

Are you having pain or discomfort at this time? YES NO

Are you happy with the appearance of your teeth? YES NO

Do you smoke? YES NO

Dental History

Have you been shown how to floss? YES NO

Have you been treated for gum disease? YES NO

Have you had orthodontic treatment? YES NO

What is your reaction to having dental work done?

Dread it

Slightly apprehensive

Don't mind it

Have you Noticed:

| | | |
|-----------------------------------|-----|----|
| Growths, swelling, sore spots? | YES | NO |
| Pain or tenderness in your teeth? | YES | NO |
| Bleeding Gums? | YES | NO |
| Sensitive Teeth? | YES | NO |
| Food Catching between Teeth? | YES | NO |
| Bad Breath? | YES | NO |

Problems which may relate to you

Occlusion (bite) or jaw joint

| | | |
|--|-----|----|
| Had tired feeling in face while chewing? | YES | NO |
| Had ringing or pain in ears? | YES | NO |
| Had pain around ears,eyes,head,or neck? | YES | NO |
| Had Clenching? | YES | NO |
| Frequent Headaches? | YES | NO |

Have you ever had any unfavorable dental experience? If yes, please describe: YES NO