Name:

How are you feeling today?_____
Do you have any dental problems now?_____
Are you in dental pain?_____
What is the reason for your visit today?_____
Are you nervous about having dental treatment?___ What are your concerns?_____

Previous Dentist name:_____
Address:_____
Phone Number:_____
Date of you last dental visit:_____ Last dental Cleaning:_____
Last full mouth of Xrays:_____
How frequently do you visit the dentist?_____
How frequently do you brush?_____ How frequently do you floss?_____
What dental aids or medicaments do you use (Toothpicks, mouthwash, etc.)?_____

Are your teeth sensitive to Hot and cold Sweets Biting /chewing
Have you noticed any mouth odors or bad tastes?_____
Do you frequently get cold sores, blisters, or any other oral lesions?_____
Do your gums bleed or hurt?_____
Does food tend to get caught in between your teeth?_____ Where?_____

Do you:
Clench or Grind your teeth while awake or asleep? _____
Bite your lips or cheeks regularly? _____
Hold foreign objects with your teeth (Pens, pins, fingernails)? _____
Mouth breathe while awake or asleep? _____
Have tired jaws, especially in the morning? _____
Smoke or Chew tobacco? _____
Snore? _____

Consume the following: Soda candy coffee chewing gum

Have you ever had: (circle what applies)
Orthodontic treatment
Periodontal (Gum) Treatment
Serious injury to mouth or head
Oral Surgery (teeth removed)
Mouth Guard or Nightguard
Root Canal Treatment

Does your jaws: (circle what applies)
Click or pop Get sore
Make it difficult to open or close
Become painful
Make it difficult to chew

Are you satisfied with your teeth's appearance?_____
Have you had an upsetting dental experience?_____
Is there anything else about having dental treatment that you would like us to know?