Patient's Name_____

Purpose of initial visit_____
Are you aware of a problem? _____
How long since your last dental visit? _____
What was done at that time? _____
Previous dentist's name_____
Home Address: _____
Home Phone: _____ Work Phone: _____Cell Phone: _____
When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? YES NO
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed? YES NO
   Why? _____
10. Have they been replaced? _____
11. How have they been replaced?
    a. Fixed bridge _____Age_____
    b. Removable bridge _____Age_____
    c. Denture _____Age_____
    d. Implant _____Age_____
12. Are you happy with the replacement? YES NO
    If yes, explain_____
13. Would you like to know more about permanent replacements? YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO
15. Do you clench or grind your teeth? YES NO
16. Does your jaw pop or click? YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
18. Do you have frequent headaches, neck aches or shoulder aches? YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to: HOT COLD SWEETS PRESSURE
21. Do your gums bleed or hurt? YES NO
    When?_____
22. Do you experience dry mouth? YES NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ..... YES NO
25. Are any of your teeth loose, topped, shifted or chipped? YES NO
26. Are you unhappy with the appearance of your teeth? ..... YES NO
27. How do you feel about your teeth in general _____
28. Do you feel your breath is offensive at times? ..... YES NO
29. Have you ever had gum treatment or surgery? .....YES NO
    What? _____
    Where? _____

When? _____

30. Have you ever had any orthodontic work? ..... YES NO

31. Have you had any unpleasant dental experiences or is there anything about dentistry that your strongly dislike? _____

32. Do you have any questions or concerns? ..... YES NO

I certify that the above information is complete and accurate

PATIENTS / GUARDIANS SIGNATURE_____DATE_____