Dr. Backiel and Associates
Creating Beautiful Smiles
2 Penn Center, 1500 JFK Blvd, Philadelphia PA

Name_____

Purpose of initial visit_____

Are you aware of a problem? _____

How long since your last dental visit? _____

What was done at that time? _____

1. Have you ever had any problems or complications with previous dental treatment?
☐YES ☐NO

2. Do you clench or grind your teeth? ☐YES ☐NO

3. Does your jaw pop or click? ☐YES ☐NO

4. Have you experienced any pain or soreness in the muscles or your face or around your ear?
☐YES ☐NO

5. Do you have frequent headaches, neck aches or shoulder aches? YES ☐ NO ☐

6. Are you unhappy with the appearance of your teeth? ..... ☐YES ☐NO