PATIENT'S NAME_____ **DATE:**_____

Primary Reason for this dental Appointment: ☐ Extractions ☐ Emergency ☐ Consult

DENTAL HISTORY PLEASE CHECK:

Do you have a specific dental problem? If yes, please describe:_____ ☐ Yes ☐ No

_____

Are you having pain or discomfort? ☐ Yes ☐ No

Do you have dental examinations on a routine basis? ☐ Yes ☐ No

Date of last dental exam_____ Date last dental hygiene visit_____ ☐ Yes ☐ No

Date of last full-mouth x-rays (16-20 small films or pano)_____ ☐ Yes ☐ No

Are you having any gum tissue discomfort or bleeding? If yes, please explain:_____ ☐ Yes ☐ No

_____

Please check the techniques you use on a daily basis to clean your mouth:

☐ hand brushing ☐ electric toothbrush ☐ flossing ☐ irrigation device (i.e., waterpik)

☐ toothpicks ☐ rubber tips ☐ specialty brushes ☐ fluoride rinse/gel

☐ mouthwash ☐ prescription oral rinse (i.e., peridex) ☐ other:_____

Does food catch between your teeth? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you have any missing teeth? ☐ Yes ☐ No

Do you have difficulty swallowing? ☐ Yes ☐ No

Do you have difficulty chewing? ☐ Yes ☐ No

Do you have any of the following? Dental Implants? ☐ Yes ☐ No

removable partial dentures? ☐ Yes ☐ No full dentures? ☐ Yes ☐ No

Do you want to keep your remaining teeth as long as possible? ☐ Yes ☐ No

Do you have any popping, clicking or discomfort in your jaw joint? ☐ Yes ☐ No

If yes, please explain:_____

Do you clench or grind your teeth? ☐ Yes ☐ No Do you wear a bite splint? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

Are there any sores or growths in your mouth? ☐ Yes ☐ No

If yes, please explain:_____

Would you like whiter teeth? ☐ Yes ☐ No

Are you happy with your smile? If no, what would you like to change?_____

Which type of restorations do you prefer?

☐ Gold ☐ Porcelain ☐ Silver Fillings ☐ White Fillings ☐ Unsure

Do you require premedication? ☐ Yes ☐ No

Have you had problems with any dental anesthetics? ☐ Yes ☐ No

If yes, please explain_____

Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

If yes, please explain_____

If necessary, would you like nitrous oxide ("laughing gas") for dental procedures? ☐ Yes ☐ No

In your opinion, how can we make your dental visits more pleasant for you?_____

Name of your previous dentist_____

What did you like best_____

What did you like least?_____