_____ _____

PATIENT **DATE**

What is the reason for today's visit? _____

Have you had any problems associated with dental treatment? _____

Have you had an unfavorable reaction to local anesthetic? _____

Would you like to change the appearance of your teeth and smile? _____

If so, what would you change or improve? _____

Is it your desire to keep your teeth as long as possible? _____

Does dental treatment make you anxious? _____

If so, □ Slightly □ Moderately □ Extremely

What can we do to make you less anxious? _____

What is your main concern about your dental health? _____

PLEASE CHECK ALL CONDITIONS THAT CURRENTLY OR PREVIOUSLY APPLY

GENERAL

□ BLISTER/SORES IN MOUTH/LIPS □ ONLY CHEW ON ONE SIDE OF MOUTH
□ FOOD TRAPS BETWEEN TEETH □ SENSITIVITY TO SWEETS □ SENSITIVITY TO BITING
□ MISSING TEETH □ LOOSE TEETH □ DRY MOUTH
□ HISTORY OF ORTHODONTIC TREATMENT □ HAVE REMOVABLE DENTAL APPLIANCES
□ BURNING SENSATION ON TONGUE □ NONE OF THE ABOVE

_____
_____
_____

PERIODONTAL

□ BLEEDING GUMS □ SWOLLEN OR TENDER GUMS □ BAD TASTE
□ BAD BREATH □ TREATMENT FOR PERIODONTAL DISEASE □ NONE OF THE ABOVE

_____
_____
_____

HABITS

□ FINGERNAIL BITING □ MOUTH BREATHING □ BITING CHEEKS OR LIPS
□ GRINDING TEETH □ CLENCHING TEETH □ ALCOHOL CONSUMPTION
□ SMOKING □ CHEW TOBACCO □ NONE OF THE ABOVE

_____
_____
_____

TMJ

□ HISTORY OF BROKEN FILLING □ HISTORY OF BROKEN TEETH □ FREQUENT HEADACHES
□ CLICKING OR POPPING OF JAW □ JAW PAIN OR TIREDNESS □ PAIN AROUND EAR (S)
□ CHANGES IN BITE □ DIFFICULTY OPENING/CLOSING MOUTH □ SHIFTING OF TEETH
□ SENSITIVITY TO HOT □ SENSITIVITY TO COLD □ NONE OF THE ABOVE

_____
_____
_____DR .INITIALS_____