

1. Purpose of initial visit _____

 2. How long since your last dental visit? _____
 3. What was done at that time? _____
 4. Previous dentist's name: _____
 Address: _____ Phone: _____
 5. 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.

6. Have you made regular visits? Yes No
 How often? _____
7. Were dental x-rays taken? Yes No
8. Have you lost any teeth or have any teeth been removed? Yes No
 Why? _____
9. Have they been replaced? Yes No
 a. Fixed bridge _____ Age of Restoration _____
 b. Removable bridge _____ Age of Restoration _____
 c. Denture _____ Age of Restoration _____
10. Are you unhappy with the replacement? Yes No
 If yes, explain: _____

11. Would you like to know about permanent replacements? Yes No
12. Have you ever had any problems or complications with previous dental treatments? Yes No
 If yes, explain _____

13. Do you clench or grind your teeth? Yes No
14. Does your jaw click or pop? Yes No
15. Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No
16. Do you have frequent headaches, neck aches, or shoulder aches? Yes No
17. Does food get caught in your teeth? Yes No
18. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
19. Do your gums bleed or hurt? Yes No
 When? _____
20. How often do you brush your teeth? _____
21. Do you use dental floss? _____
 How often? _____
22. Are any of your teeth loose, tipped, shifted or chipped? Yes No
23. Are you unhappy with the appearance of your teeth? Yes No
24. How do you feel about your teeth in general? _____

25. Do you feel your breath is offensive at times? Yes No
26. Have you ever had gum treatment or surgery? Yes No
 When? _____
27. Have you ever had orthodontic work? Yes No
28. Have you had any unpleasant dental experiences or is there anything else we should know to make your visits more comfortable? _____

29. Do you have any questions or concerns? _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ **DATE** _____