What is the reason for your visit today? _____

Date of Last Dental Visit? _____ **Last Dental Cleaning?** _____

How often do you have dental examinations? _____

What was done at your last dental visit? _____

How often do your brush your teeth? _____ **Floss?** _____ **Other Dental aids?** _____

Do you have any dental problems now? _____

Are your teeth sensitive to:

Hot or cold? YES NO
Sweets? YES NO
Biting or chewing? YES NO
Mouth odors or bad taste? YES NO
Do you get cold sores? YES NO
Or any other oral lesions? YES NO

Do your gums bleed or hurt YES NO
Have your parents had gum disease or tooth loss? YES NO
Have you noticed loose teeth or change in your bite? YES NO
Does food get caught between your teeth? YES NO
If yes, where?_____

Do you:

Clench or grind teeth? YES NO
Bite your lips or cheeks? YES NO
Hold objects in teeth? (pencils, pipe, pins, fingernails) YES NO
Mouth breathe asleep/awake? YES NO
Have tired jaws in the morning? YES NO
Smoke/chew tobacco? YES NO

Have you ever had:

Orthodontic treatment? YES NO
Oral surgery? YES NO
Periodontal treatment? YES NO
Your teeth ground or bite adjusted? YES NO
A bite plate or mouth guard? YES NO
A serious injury to mouth or head? YES NO
Please describe_____
_____

Have you experienced:

Clicking or popping of the jaw? YES NO
Pain? (joint, ear, side of face) YES NO
Difficulty in opening/closing mouth? YES NO
Difficulty in chewing on either side? YES NO
Head, neck, shoulder aches? YES NO
Sore muscles? (neck, shoulders) YES NO

Are you satisfied with your teeth? YES NO
Would you like to keep your teeth? YES NO

Nervous about dental treatment? YES NO
If so, what is your biggest concern?
_____
Have you had a bad dental experience? YES NO
If yes, please explain_____
_____

Is there anything else about having dental treatment you would like us to know? YES NO
If yes, please explain_____

Office Use Only

Dentist Signature:_____**Date:**_____