

COMMENTS

Patient's Name: Last First Initial DOB

- 1. Purpose of initial visit:
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name: Address: Phone:
6. When was the last time your teeth were cleaned?
7. Have you made regular visits to the dentist?
8. Were dental x-rays taken?
9. Have you lost any teeth or had any removed?
10. Have the teeth been replaced?
11. What procedure?
12. Are you happy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any complications or problems with previous dental treatment?
15. Do you grind or clench your teeth?
16. Do you have frequent head, neck or shoulder aches?
17. Have you experienced any soreness or pain in the muscles on your face or around your ears?
18. Does your jaw pop or click?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to: Sweets? Hot? Cold? Pressure?
21. If yes, when?
22. How often do you brush your teeth? When? Do you floss?
23. How often?
24. Are any of your teeth chipped, tipped, loose or shifted?
25. Are you happy with the appearance of your teeth?
26. How do you feel about your teeth in general?
27. Do you feel you have bad breath at times?
28. Have you ever had gum surgery or treatment?
29. Have you ever had orthodontic work? When?
30. Have you had any unpleasant dental experiences or is there anything that you strongly dislike about dentistry?
31. Do you have any concerns or questions?

Large empty rectangular box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION GIVEN TO DISTINCTIVE DENTAL CONCEPTS IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DENTIST'S SIGNATURE DATE

ANEST. box

MED. ALERT box