Personal Information:

The following personal information will help to review your current concerns and understand your dental needs. Please answer the following questions to the best of your ability.

Are you aware of any particular dental problems that you may have? If yes, please explain.

Are you having any discomfort or pain? If yes, where, describe (throbbing, stabbing, ache etc.) level of pain.

When was your last dental visit? What was done at that time? What was the dentist's name?

What is your primary reason for your visit here?

What are your expectations?

What is your current physician's name and address?

What is your preferred pharmacy? (location as well)

Who may we thank for referring you to / recommending our office?

Emergency contact
(Other than your spouse):

Name:___________________________ Relationship:_____________________

Phone:___________________________ City they live in___________________

Dental Habits

Patient Name: ________________________________ Date:________________

It is extremely important that when considering extensive dental treatment the potential causes of your past and current dental problems are carefully examined. Please answer the following questions as accurately as possible. These answers will help in developing your dental treatment plan.

1. Do you use any of the following, if so, sugar or sugar free and how frequently? (please circle)

Candy or cough drops	sugar/sugar fee	Daily	Weekly	Monthly	Never
Chewing gum	sugar/sugar fee	Daily	Weekly	Monthly	Never
Antacids prescribed	sugar/sugar fee	Daily	Weekly	Monthly	Never
Coffee w/cream + sugar		Daily	Weekly	Monthly	Never
Drink soda/pop	sugar/sugar fee	Daily	Weekly	Monthly	Never
Drink fruit juice		Daily	Weekly	Monthly	Never
Eat fruit		Daily	Weekly	Monthly	Never
Eat desserts	sugar/sugar fee	Daily	Weekly	Monthly	Never
Chew on ice		Daily	Weekly	Monthly	Never

2. Do you have acid reflux disease or frequent heartburn?_____

3. Do you bite your nails? ______

4. Do you clench/grind your teeth? ______

5. Do you wear a night time appliance?_____ How often? Daily Weekly Monthly Never

6. If you wear a partial / complete denture do you remove it while sleeping?______

7. Does your mouth ever feel dry? How often? Daily Weekly Monthly Never

8. Do you use tobacco products?

Cigarettes / Cigars	Daily	Weekly	Monthly	Never
Chew / Snuff	Daily	Weekly	Monthly	Never

7. How important is it for you to keep your natural teeth? (both restored and unrestored) (please circle one)

Very important **Not important**

10 9 8 7 6 5 4 3 2 1

8. What are your expectations of dental treatment? What is important to you? (i.e. improve looks, improve function, or other).

9. Rate your previous experiences with dental treatment. (circle one)

Very Good **Good** **Poor**

10 9 8 7 6 5 4 3 2 1