Patient Name: _______________________________ Date: ________________

Primary Reason for dental appointment: □ Routine Exam □ Emergency □ Consultation/Second Opinion

Do you have a specific dental problem? __________________________________________________________

Have you had routine dental care in the past? ________________ Date of last dental exam: ________________

Are your teeth sensitive to: □ Cold □ Hot □ Sweet □ Biting □ Touch For how long? ___________

Describe your current dental health: □ Great □ Good □ Fair □ Poor

How often do you brush your teeth? ________________ How often do you floss? ________________

Do your gums bleed? ________________ Do you have bad breath? ________________

Have you ever had: □ Gum surgery (Periodontal Surgery) □ Braces □ TMD therapy (Jaw joint therapy)

Do you ever experience any clicking or popping sounds, or any discomfort in your jaw joint? ________________

Do you clench or grind your teeth? ________________ When? ________________

Do you smoke or chew tobacco products? ________________ How much/how long? ________________

Do you have any sores or growths in your mouth? ________________

If displeased with your mouth or smile, please explain: ________________

Are your teeth in alignment (straight)? ________________

Do you have any spacing between your teeth you dislike? ________________

Do you dislike the color of your teeth? ________________

Are your teeth wearing on the biting/chewing surfaces? ________________

Do you have old dental work that you dislike the look of? ________________

Please explain any changes that you would like to make to your teeth not described above: ________________

Have your past dental experiences all been positive? ________________

Previous dentist: ________________

Date of last Full Mouth X-rays (FMX) or Panoramic X-ray: ________________

Doctor’s Comments: ________________

Signature of Patient/Responsible Party: _______________________________ Date: ________________