Patient Name _____

Dental Health

When was your last dental visit?_____

Purpose of visit_____

Previous dentist _____

Please contact your former dentist for a copy of your records and x-rays.

Have you received treatment for any of the following:

Orthodontics	Yes ☐	No ☐
Oral Surgery	Yes ☐	No ☐
Periodontal (gum) Treatment	Yes	No ☐
TMJ Treatment	Yes ☐	No ☐

How often do you do the following:

Brush: _____

Floss: _____

Rubber Tip: _____

Toothpick/other _____

Have you experienced any of the following:

Sweet sensitivity	Y ☐	N ☐	Grinding at night	Y ☐	N ☐
Hot sensitivity	Y ☐	N ☐	Clenching during the day	Y ☐	N ☐
Cold sensitivity	Y ☐	N ☐	Tired muscles or jaw	Y ☐	N ☐
Biting or chewing pain	Y ☐	N ☐	Clicking or noises of the jaw	Y ☐	N ☐
Bleeding gums	Y ☐	N ☐	Jaw pain	Y ☐	N ☐
Frequent mouth sores	Y ☐	N ☐	Trouble opening or closing	Y ☐	N ☐
Injury to teeth or jaw	Y ☐	N ☐			

Have you experienced any of the following during or after dental treatments:

Abnormal bleeding	Y ☐	N ☐
Fainting	Y ☐	N ☐
Trouble reclining in dental chair	Y ☐	N ☐
Allergic reaction	Y ☐	N ☐
Complications from nitrous oxide	Y ☐	N ☐
Other complications	Y ☐	N ☐

Would you like to change:

Appearance of your smile	Y ☐	N ☐
Color of your teeth	Y ☐	N ☐
Shape of your teeth	Y ☐	N ☐
Position of your teeth	Y ☐	N ☐

For your comfort, please check the following items you would like to use:

Nitrous oxide ☐

Music ☐

Neck pillow ☐

Are you having any dental problems that require immediate attention?_____

_____

Is there anything about going to the dentist that concerns you?_____

_____

I will allow Dr Szafarek to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow her permission to discuss my conditions with any physician and to request medical information from him/her

Signature_____ Date_____