

EMERGENCY CONTACT INFORMATION

* In case of an emergency, who should we contact?

- Please write their name, relationship to the patient, and contact number.

Contacts first and last name:	
Relationship to the patient:	
Contact's phone number:	

NEW PATIENT DENTAL HISTORY AND SYMPTOMS

1. What is the reason for your visit today? _____
2. Are you currently experiencing any dental pain or discomfort? If yes, please briefly explain.

3. What is the date of your last dental appointment? (month/year) _____
4. What was done at your last dental appointment? Please briefly explain. _____

5. When was the last time you had dental x-rays done? (month/year) _____
6. Have you ever had a serious injury to your head or mouth? If yes, please briefly explain.

7. Have you ever had any problems with dental treatment in the past? If yes, please briefly explain.

8. Have you ever had a reaction to, or problem with, dental anesthetics? If yes, please briefly explain.

9. Are you unhappy with your smile? If yes, please briefly explain. _____

10. Have you ever had ortho? _____

Please check any/all the apply:

• It is hard to open my mouth.	• It hurts to chew, bite, and/or swallow.	• I have had periodontal (gum) treatment before.
• I have/had sores or growths in/on my mouth.	• I clench and/or grind my teeth.	• I have earaches and neck pains.
• Dental treatment makes me nervous.	• My gums bleed when I brush/floss.	• My jaw pops, clicks, and hurts.