GUTTORMSEN & HOFFNER DENTAL

EMERGENCY CONTACT INFORMATION

Contact's 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 any orthodontic work done before?_____
11. Please check any of the following that apply to you:
    - ☐ 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 sore 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.

      _____