INITIAL CONCERN ____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST FULL MOUTH SERIES OF X-RAYS

1. Do you have any dental problems now?........................ Yes No

2. Are any of your teeth sensitive to: Hot or Cold?.......... Yes No

Sweets? .... Yes No

Biting or Chewing?.. Yes No

3. Have you ever had:

a) Orthodontic Treatment? .... Yes No

b) Oral Surgery? .... Yes No

c) Periodontal Treatment? .... Yes No

d) Your teeth ground or the bite adjusted? .... Yes No

e) Worn a bite plate or other appliance? .... Yes No

4. Have you noticed any loosening of your teeth? .... Yes No

5. Does food tend to become caught between your teeth?.. Yes No

6. Do you suffer from pain and/or swelling of your gums? ... Yes No

7. Do your gums often bleed when you brush your teeth? .. Yes No

8. Have your parents experienced gum disease? .... Yes No

9. Problems of the jaw. Have you experienced:

a) Clicking of the jaw? .... Yes No

b) Pain (Joint, Ear, Side of Face)? .... Yes No

c) Difficulty in opening or closing? .... Yes No

d) Difficulty in chewing? .... Yes No

10. Habits. Do you:

a) Clench or grind your teeth while awake or asleep? .... Yes No

b) Bite your lips or cheeks regularly? .... Yes No

c) Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)? .... Yes No

d) Mouth breathes while awake or asleep? .... Yes No

11. Do you feel very nervous about having dental treatment?..Yes No

12. Have you ever had an upsetting experience in a Dental

Office?.. Yes No

13. Do you expect to eventually lose your teeth? .... Yes No

14. Are you dissatisfied with the appearance of your teeth? .. Yes No

15. Is there anything else about having dental treatment that bothers you? .... Yes No

Explanation:

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