Patient Name:______________________________ **Today's Date:**________________________
Email:______________________________________ **Phone:**______________________________

How did you find us? Circle one
-Phone Book
-Friend/Family: ___________________________
-Internet: Facebook Pop up Add Our Website Other Internet
-Other (please specify):_____________________

What brings you in today?____

Do you have any dental concerns?____

Have you ever had a dental cleaning before? **YES / NO**

Have you ever had braces? **YES / NO**

Have you ever had any fillings or other dental work? **YES / NO**

Do you have dental anxiety? **YES / NO**

How often do you: **brush?**________________ **floss?**__________________

Do you use fluoride toothpaste? **YES / NO**

Have you ever had a tooth pain, abscess or other tooth emergency? **YES / NO**

Are you having tooth/gum pain today? **YES / NO**

Do you have tooth/gum sensitivity? **YES / NO**

Have you ever been told you have gum disease(periodontitis)? **YES / NO**

Have you ever had deep cleanings /gum treatment(Scaling and root planning)? **YES / NO**

Do your gums bleed when you brush or floss? **YES / NO**

Do you have any oral habits? (nail biting, biting inside of cheek or lip, chewing on pen tops, etc) **YES or NO**

Do you clench or grind your teeth? **YES / NO**

Do you have popping or clicking in your jaws? **YES / NO**

Do you have jaw pain? **YES / NO**

Do you have missing teeth? **YES / NO**
If so, are you interested in tooth replacement? **YES / NO**

Do you or have you ever had dentures? **YES / NO**

Do you have a history of any head or neck cancer? **YES / NO**

Have you ever had any major injuries to the head/neck area? **YES / NO**

Have you ever had oral surgery including tooth/wisdom tooth extractions? **YES / NO**

Do you use or have you ever regularly used any kind of tobacco products? **YES / NO**