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**Patient Information**

So that we may provide you with the best possible care, please complete this informational form.

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

What made you call our office and schedule an appointment? \_\_\_\_\_

How long has it been since your last dental appointment? \_\_\_\_\_

Is there anything you liked or disliked about your previous dental experiences?

Likes \_\_\_\_\_

Dislikes \_\_\_\_\_

Do you have a history of, or now have: (if so, feel free to comment)

Broken/chipped teeth: \_\_\_\_\_

Loose teeth : \_\_\_\_\_

Worn teeth: \_\_\_\_\_

Food Traps: \_\_\_\_\_

Tender or Swollen Gums: \_\_\_\_\_

Bleeding gums: \_\_\_\_\_

Missing teeth: \_\_\_\_\_

Do any of the following cause tooth discomfort?

\_\_\_\_ Hot \_\_\_\_ Cold \_\_\_\_ Sweets \_\_\_\_ Chewing

Comments: \_\_\_\_\_

Do you usually have cavities? \_\_\_\_\_

Do you bite your nails or any other objects routinely, (thread, fishing line, tape, cellophane, ice popcorn hulls, hair pins)? \_\_\_\_\_

Have you ever been told you have periodontal disease?  Y  N

If yes, did you have treatment?  Y  N

Have you had orthodontics?  Y  N

For how long? \_\_\_\_\_ How long ago? \_\_\_\_\_

Do you have any of the following:

Non-removable Bridge(s)? \_\_\_\_\_ Removable Partial: \_\_\_\_\_

Full Dentures \_\_\_\_\_ Dental Implant(s): \_\_\_\_\_

Are you comfortable with your replacements? \_\_\_\_\_

Have you had treatment recommended that you have not had completed?

If yes, please comment \_\_\_\_\_

How often do you:

Brush \_\_\_\_\_ Floss \_\_\_\_\_

Stimudent \_\_\_\_\_ Proxabrush \_\_\_\_\_

Have you bleached your teeth?  Yes  No

Are you interested in Bleaching?  Yes  No

Do you have frequent headaches?  Y  N

If yes, where are they located?  In front of the ear

Above the eyes

Back of the neck

Along the lower jaw

Other \_\_\_\_\_

How often do you have headaches? \_\_\_\_\_

Do you have any of the following? If so, please describe:

Neckaches \_\_\_\_\_

Shoulder Pain \_\_\_\_\_

Ear Pain \_\_\_\_\_

Ringling in the ears \_\_\_\_\_

Dizziness \_\_\_\_\_

Change in hearing \_\_\_\_\_

Are you experiencing any jaw or facial pain?  Yes  No

If yes, does it keep you from doing anything?  Yes  No

If yes, what? \_\_\_\_\_

Do you feel you sleep well?  Yes  No

If no, why not? \_\_\_\_\_

Do you awaken suddenly while sleeping?  Yes  No

Do you snore  Yes  No

Do you take medication for relaxation?  Yes  No

If yes, what and how often? \_\_\_\_\_

Have you ever had a nervous stomach, ulcers, skin disease?  Yes  No

Have you had Gastro-Intestinal reflux disorder?  Yes  No

If yes, are you being treated?  Yes  No

Do you have arthritis?  Yes  No

Have you ever had a blow or injury to the jaw?  Y  N

If yes, please describe \_\_\_\_\_

Date of injury \_\_\_\_\_

Has your jaw ever locked open?  Yes  No

locked closed  Yes  No

When? \_\_\_\_\_ How often? \_\_\_\_\_

Do you clench or grind your teeth? Y  N  \_\_\_\_\_ clench  grind

If yes, please describe \_\_\_\_\_

Are your jaw joints painful or tender?  Yes  No

If yes, please describe \_\_\_\_\_

Do you or did your joints hurt or become tender when you chew or talk?

Yes  No

Regularly  Occasionally

Right side  Left side  Both sides

Do you or have you had tenderness in either jaw joint or muscles when you open wide?  Y  N

Right Side  Left Side  Both Sides

Do you or did you ever hear any sounds in your jaw? Yes  No

Clicks  pops  grating

How long have you noticed this \_\_\_\_\_ months \_\_\_\_\_ years

Which side  Right  Left  Both

Is it worse in  AM  PM  When eating  All the time

Do you consider yourself to be under a lot of stress?  Y  N

Does your bite feel comfortable?  Yes  No

If not, please describe \_\_\_\_\_

Have you noticed any changes in your bite?  Yes  No

If yes, please describe \_\_\_\_\_

Can you chew comfortably on both sides of your mouth?  Yes  No

Have you ever been told you have jaw concerns?  Yes  No

Have you ever been treated for your jaw concern?  Y  N

If yes, please indicate with a "X" what treatment you received for your jaw concern and check any areas treatment was received for other reasons.

<input type="checkbox"/> Splint	Did the treatment help?	<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Bite Adjusted		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Medication		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Orthodontics ( Braces)		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Physical therapy for the jaw		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Surgery of the jaw		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Counseling		<input type="checkbox"/> Y	<input type="checkbox"/> N
<input type="checkbox"/> Other _____			

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On a scale of 1-10, how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

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Is there anything you would like to change about your smile?