Oral Health History and Patient Communication Preferences

Please answer the following:

NO YES Have you ever had periodontal (gum tissue) treatment, such as: deep cleanings, root planing, or periodontal surgery?

NO YES Have you ever been pre-medicated for dental treatment?
If yes, why? _____

NO YES Have you been anxious about having dental treatment?
If yes, would you be comfortable sharing why? _____

NO YES Have you ever had orthodontic treatment?
If yes, when? _____

NO YES Have you whitened your teeth in the past?
If yes, what method? _____

NO YES Is it important for you to see the same Dentist and Hygienist for each visit?

Preferred Method of Communication:

Email: YES NO
If yes, preferred email address: _____

Text Message: YES NO

Phone:

_____ Home YES NO
_____ Cell YES NO
_____ Work YES NO

We encourage you to share any concerns you may have regarding your oral health or smile:

Please check all that apply:

- ☐ Jaw joint pain
- ☐ Clenching or grinding of teeth
- ☐ Discolored teeth
- ☐ Crowding/Crooked teeth
- ☐ Missing teeth
- ☐ Spaces in between teeth
- ☐ Loose tooth/teeth
- ☐ Tooth shape or size
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Food gets caught in between teeth
  If yes, where? _____
- ☐ Unhappy with appearance of teeth
- ☐ Overbite
- ☐ Underbite
- ☐ Uncomfortable bite
- ☐ Old fillings (gold or silver)
- ☐ Old crowns
- ☐ Speech problems
- ☐ Too much gum tissue when I smile
- ☐ Difficulty chewing
  If yes, where? _____
- ☐ Bad breath

With whom may we discuss your dental care and visits?

- ☐ All Family
- ☐ Spouse:_____
- ☐ Do not share any of my information with anyone.
- ☐ Appointment date and times only
- ☐ Appointment date and times only

Signature: _____ Date: _____

I have interest in the following:

- ☐ Teeth Whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth-colored fillings
- ☐ Dental implants
- ☐ How to prevent periodontal disease
- ☐ At-home oral hygiene care
- ☐ Periodontal treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers
- ☐ More information regarding TMJ / TMD / TMJD

How did you find our dental practice?

- ☐ Current patient: _____
- ☐ Web search (please circle): Google Yahoo! Bing Other: _____
- ☐ Other: _____

Gathering the following information can be helpful for future treatment and insurance reimbursements (if applicable).

What are your goals in coming to our practice today? _____
What is important to you in a dentist or dental practice? _____
If you left your previous dentist, what are the reasons? _____
Date of last radiographs (x-rays) and exam: _____
Date of last hygiene continuing care appointment: _____
Previous Dentist name and contact information: _____
Have you had problems with prior dental treatment? YES / NO If yes, please explain: _____
Are you a full time student? YES / NO If yes, please provide: _____