PLEASE PRINT CLEARLY

Mr / Mrs / Ms / Miss (circle) Male / Female (circle)

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: MM/DD/YYYY _____

Address: _____

City: _____ Postal Code: _____ Email: _____

Home #: _____ Bus. #: _____ Cell #: _____

How did you hear about our clinic? _____

Employer / School: _____

Do you have dental insurance? Y N Do you have a 2nd dental insurance? Y N

DENTAL HISTORY

What is your main reason for seeking dental treatment today? _____

Date of last dental visit: _____ Date of last x-ray: _____

Have you ever had any of the following? (please circle):

Jaw Surgery Orthodontic Treatment Splint/Nightguard Wisdom Teeth Extracted Motor Vehicle Accident

Do you have any sore, aching, or sensitive teeth? Y N Do your gums bleed when brushing or eating? Y N

Has your jaw ever locked? Y N

Have you ever experienced any of the following jaw problems? (please circle):

Popping/clicking in your jaw joints Pain in your jaw joint Pain around your ear or the side of your face

Difficulty in opening or closing Pain when teeth are clenched Pain or difficulty while chewing

Do you have any of the following habits? (please circle):

Clenching or grinding your teeth while awake or asleep Biting your cheeks or lips Mouth breathing while awake or sleep

Placing foreign objects in your mouth (pencils pens nails pipes pins finger nails)

Do you have any emotional concern about having dental treatment? Y N

If Yes, please explain: _____

Do you have any questions or concerns? _____

_____

_____