Welcome
Dental Concerns Questionnaire

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Please take a few moments to answer these questions concerning your previous and current dental concerns. By providing these answers, it enables our staff to better serve your needs and address your concerns.

What is your main concern today? ____

When was your last dental visit? ______________________________ Where? ____________________________

Did you have x-rays taken? __________________________________ Can you provide a copy to us? _____________

Have you ever had periodontal treatment/ or periodontal surgery ___________Deep cleanings__________________

Have you been previously told you need periodontal therapy? ____

How many times a day do you brush? ____________________ Floss? ______________Use of Fluoride? __________

Do you have any teeth that are sensitive? Explain ____

Do you avoid eating certain foods because it hurts to chew? ____

Do you clench or grind your teeth? ____________________________ Currently wear a guard at night? __________

Do your jaws ever feel tired, pop, or ache? ____

Can you chew equally on both sides or do you prefer to chew on one side? __________________________________

Do you have frequent headaches or jaw pain in the morning? ____

Have you ever had orthodontic treatment? ____

Do you have any loose or broken fillings? ____

Do you have any loose teeth? ____

Do you have noticeable wear on your front teeth? ____

Do you have missing teeth? __________________________ Have they been replaced? _________________________

If so, how? Fixed Bridge ________ Removable Partial ________ Full Denture ________ Dental Implant _____________

How do you feel about the appearance of your smile? ____

Have you ever had any cosmetic dentistry done to improve your appearance? _______________________________

Have you ever considered whitening your teeth? ____

Any other concerns about your dental health that you wish to share with us:

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How did you hear about us? ________Webpage _________Friend _______Phone Directory ________ Other__________

Annual Medical History Update

Thank you for your continued trust in providing dental care for you and your family. Please advise our staff of any changes in medications or medical history so that we are up to date on concerns that may impact your dental care. Incorrect or missing information can be dangerous to your health.

Have there been any changes in your Medical History since you were last seen in our office?

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Have you had any changes in your health, hospitalizations, or surgeries since your last visit? Explain

____

____

Have there been any changes in medication since your last visit? Explain or list

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____

Are you currently under the care of a physician? If yes, why?

____

____

Have you had any head or neck trauma since your last visit?

____

Are you pregnant or trying to get pregnant?

____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as he/she deems appropriate. I understand that I have the right to refuse or decline treatment as indicated above; unfortunately such refusal could have a negative impact on my dental health, medical health and/or quality of life. Refusal to allow the collection of required diagnostic aids, continual postponement of treatment, and missed appointments could result in dismissal from the practice.

I further authorize the release of any information, including diagnosis, radiographs and records of treatment or examinations rendered to my insurance company, and/or consulting professionals. I understand that I am personally responsible for payment of all fees for dental services provided in this office for myself and my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. A late cancellation/missed appointment fee of $25.00 will be charged for failed appointments or cancellations that occur within 24 hours of your appointment.

Patient or Patient Representative Signature ___________________________________ Date ____________________________