

GETTING TO KNOW YOU:

NAME: _____ DATE: _____

What name would you like us to call you? _____

Purpose of today's visit:

Why have you decided to deal with this now?

Have you consulted with any other dentist about this? Yes No If yes, what was discussed or done?

When was your last dental & cleaning check up? _____

Previous dentist? _____

Do you now have or have you ever had any of the following:

- | | | | |
|-----------------------------------|--|-------------------------------|--|
| Have gum disease (gingivitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Food collection between teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grind your teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores, blisters or growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to: Cold | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sweets | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Biting/Chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loose or broken teeth or fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Would you like to know what options are available to you to:

- | | | | |
|-----------------------------------|--|-----------------------------|--|
| 1. Create a more Attractive Smile | <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Keep your Teeth for Life | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Look Younger | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

What would you like to see done now?
