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NEW PATIENT INTERVIEW and DENTAL HISTORY

Name ______________________________ DOB ____________________

Do you have or wish to discuss any of these problems:

1. Pain or discomfort associated with your mouth?	YES	NO
2. Snoring?	YES	NO
3. Tooth clenching or grinding?	YES	NO
4. Tender face or neck muscles?	YES	NO
5. Migraines or headaches?	YES	NO
6. Jaw joint pain?	YES	NO
7. Clicking or popping in jaw joint?	YES	NO
8. Bleeding gums?	YES	NO
9. Bad breath?	YES	NO
10. Bad taste in your mouth?	YES	NO
11. Do you have sensitivity to any of the following:		
i.Hot	YES	NO
ii.Cold	YES	NO
iii.Sweet	YES	NO
iv.Biting pressure	YES	NO
12. Do you think you have active decay or gum problems?	YES	NO
13. Have you ever had any unfavorable reaction from a local anesthetic?	YES	NO
14. Have you had any serious trouble associated with any previous dental treatment?	YES	NO
15. Do you have a dental implant?	YES	NO
16. How long since your last full mouth x-rays?	________	
17. How long since your last dental treatment?	________	
18. Does dental treatment make you nervous?	YES	NO
If yes, Circle	Slightly Moderately	Extremely
19. Would you desire to be pre-sedated?	YES	NO
20. Do you wish to speak to the Dr. privately about any matter?	YES	NO