A few questions to get to know you better

Name____

DOB__________________

1. Do you feel nervous about dental treatment? No Yes: Please elaborate ________________________

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2. Have you ever had an unfavorable reaction from local anesthetic? No Yes: ___________________

3. Are you currently in pain? No Yes: ____

4. Do you have jaw joint pain or limitations with opening your mouth? No Yes: _________________

5. Do you require antibiotics before dental treatment? No Yes: ________________________________

6. When was your last dental visit? __________________ Last dental cleaning? __________________

7. Have you ever been numb for a cleaning: No Yes: ____

8. Do your gums ever bleed? No Yes: ____

9. Do you have areas where food catches between your teeth? No Yes: __________________________

10. Do you have any old fillings or dental work that you would like to have changed? No Yes:______

11. Have you noticed any spots or stains that cause you to be self-conscious about the appearance of your teeth? No Yes: ____

12. Have you been treated with braces or Invisalign in the past? No Yes: ___Braces_____Invisalign___

If not, are you interested? ______Yes, I am Interested in Ortho___________No, not at this time________

13. Do you use a retainer or night guard? No Yes: ________Retainer________Night Guard__________