New Patient History - Getting To Know <u>You</u>

Patient Name: _____ Date: _____

Preferred name/nickname?

Who may we thank for referring you?

Career/profession:

College(s) attended:

Where are you from/where did you grow up?

Family/kids/pets?

MEDICAL: When was your last well visit/MD visit?

Current medical problems?

DENTAL: Approximate date of last dental visit and cleaning?

(Office Use) Brought x-rays Date: _____

Any pain or tooth problems?

Gums: Have you ever received a numbing for cleaning?

TMJ: Any current/past TMJ pain or problems? (circle)

Habits: Are you or have you ever been told that you are a grinder/clencher/nail biter? (circle)

Do you wear a Night Guard currently/previously/recommended? (circle)

*(Office Use) In office/OTC Date:*_____

Smoker? If so, how many years and how many cigarettes/packs per day?

Have you ever been put on a bone density medication for cancer or osteoporosis?

Do you snore? Have you been diagnosed with sleep apnea? Do you use a CPAP/Device? (circle)

Have you ever had a sleep study? If so, when?

Have you had orthodontics (braces or aligner/Invisalign)? (circle)

*(Office Use) Date of treatment:*_____

Have you had any of these: (circle)

1. Fillings
2. Crowns (caps)
3. Root canals
4. Wisdom teeth extraction
5. Bonding on front teeth
6. Esthetic Crowns/veneers on front teeth

Appearance: Are you happy/satisfied/dissatisfied with your smile? (circle)

If you could change anything about your smile what would that be?

Would you be interested in an affordable, safe and easy way to whiten your smile?

What can we do to improve your experience/satisfaction at our practice versus your care at your previous office(s)?

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