

# WELCOME

The Center for Cosmetic and Family Dentistry

Patient's Name \_\_\_\_\_  
Last First Initial Date of Birth

1. Purpose of initial visit? \_\_\_\_\_
2. How long has it been since your last dental visit? \_\_\_\_\_
3. When was the last time your teeth were cleaned? \_\_\_\_\_

**CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" NEXT TO THE QUESTION.**

4. Were dental x-rays taken? YES NO
5. Have you lost any teeth or have any teeth been removed? YES NO
6. Have they been replaced? YES NO
7. Are you unhappy with your replacement? YES NO  
If yes, please explain \_\_\_\_\_
8. Have you ever had any problems/ complications or unpleasant dental experiences?  
If yes, please explain \_\_\_\_\_
9. Do you clinch or grind your teeth? YES NO
10. Does your jaw click? YES NO
11. Have you experienced any pain or soreness in the muscles or your  
face or around the ear? YES NO
12. Do you have frequent headaches, neckaches or shoulder aches? YES NO
13. Does food get caught in your teeth? YES NO
14. Are any of your teeth sensitive? YES NO
15. Do your gums bleed or hurt? YES NO
16. Do you experience dry mouth? YES NO
17. How often do you brush your teeth? \_\_\_\_\_
18. How often do you floss your teeth? \_\_\_\_\_
19. Are any of your teeth loose, tipped, shifted or chipped? YES NO
20. Are you unhappy with the appearance of your teeth? YES NO
21. Do you feel your breath is offensive at times? YES NO
22. Have you ever had gum treatment or surgery? YES NO  
When \_\_\_\_\_
23. Have you had any orthodontic work? YES NO
24. Do you have any questions or concerns? YES NO

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Doctor/Staff Comments** \_\_\_\_\_

\_\_\_\_\_

**DENTAL HISTORY**