GETTING TO KNOW YOU

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NAME: ____DATE: _______________

What name would you like us to call you? ____

Please describe the reason for your consultation today:

____

____

____

____

How long has this been going on and what other events apply to 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 check up? _______________

Who is your regular or previous dentist? ____________ May we request records?___________________

Have you noticed or has any dentist or hygienist ever said that you:

Have gum disease (gingivitis) ☐ **Yes** ☐ **No**

Grind your teeth ☐ **Yes** ☐ **No**

Clicking or popping jaw ☐ **Yes** ☐ **No**

Jaw Pain or tiredness ☐ **Yes** ☐ **No**

Pain around ear ☐ **Yes** ☐ **No**

Experience nasal Congestion ☐ **Yes** ☐ **No**

Lip or cheek biting ☐ **Yes** ☐ **No**

Loose or broken teeth or fillings ☐ **Yes** ☐ **No**

Food collection between teeth ☐ **Yes** ☐ **No**

Sores, blisters or growths ☐ **Yes** ☐ **No**

Bad Breath ☐ **Yes** ☐ **No**

Do you wear a CPAP?
When did you start? __________

Frequent Eve Infections?

What is your usual Bedtime? __________
Wake time? __________

Sensitivity to: ☐ **cold** ☐ **heat** ☐ **sweets** ☐ **when biting or chewing**