DENTAL INFORMATION

What is the specific reason for making this appointment? _____

Date of last dental examination_____ Date of last cleaning_____

Have you ever had a "deep cleaning" (root planing and scaling)? ❑ yes ❑no When?_____

Do you have additional appointments scheduled with your dentist? ❑ yes ❑no When? _____

For what purpose? _____

How frequently do you have your teeth professionally cleaned? _____

How often do you brush your teeth? _____ Floss?_____ When do you brush/floss? _____

Are you satisfied with the appearance of your teeth? ❑ yes ❑no

Are you chewing satisfactorily? ❑ yes ❑no

In your opinion, what is your general dental condition? _____

How do you feel about keeping your teeth? _____

Are you apprehensive about dental treatment? ❑ yes ❑no If so, for what reason? _____

Would you like to discuss options for sedation? ❑ yes ❑no

Do you have now or have you ever had?

Pain in mouth or face	❑ yes ❑no	Periodontal (gum) treatment	❑ yes ❑no
Bleeding gums	❑ yes ❑no	Orthodontic treatment	❑ yes ❑no
Loose teeth	❑ yes ❑no	Mouth breathing	❑ yes ❑no
Bad breath	❑ yes ❑no	Injury to face or jaw	❑ yes ❑no
Unpleasant taste	❑ yes ❑no	Popping, clicking or pain in jaw	❑ yes ❑no
Clenching or grinding of teeth	❑ yes ❑no	Pain around ears	❑ yes ❑no
Swelling or lumps in mouth	❑ yes ❑no		

Consent:
I certify that the above information is complete and correct to the best of my knowledge. I will not hold Dr. Chapman or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize Dr. Chapman and staff to take x-rays, photographs, or any other diagnostic aids deemed appropriate by Dr. Chapman to make a thorough diagnosis of my dental needs.

_____

Signature of Patient, parent or Guardian Date

_____

Reviewed by

Thank you for taking the time to provide this information. Thomas J. Chapman, DDS