EDGAR ALB, DMD, PA.

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THANK YOU FOR TAKING THE TIME TO COMPLETELY FILL OUT THIS QUESTIONAIRE. THIS IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE.

DENTAL HISTORY

How long since you have seen a Dentist? ______

LAST DATE OF COMPLETE DENTAL EXAM: ______

LAST DATE OF FULL MOUTH XRAYS &/or PAN (Machine that rotates around your head or 18 small films): ______

PLEASE CHECK THE APPROPRIATE BOXES.	YES	NO
Are you having Problems Now?	☐	☐
What? ______		
Is your present dental health poor?	☐	☐
Do you wear Dentures? *(Please Circle: Partials or Full)*	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about Permanent Replacement?	☐	☐
Have you had bad experiences in the past?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had any Periodontal (Gum) Treatments?	☐	☐
Do your gums bleed?	☐	☐
If so, do they feel tender or irritated?	☐	☐
Are your teeth sensitive to (please circle): hot? cold? sweets? pressure?	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have (please circle): Headaches? Earaches? Or Neck Pains?	☐	☐
Do you have (please circle): Loose? Tipped? Or Shifting Teeth?	☐	☐
Have you had orthodontic treatment on your teeth? (Braces? Retainers?)	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Would you like your smile to look better or different?	☐	☐
Do you have problems with teeth or fillings breaking?	☐	☐
Do you regularly use dental floss?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐

Name of Previous Dentist: ______

Address of Previous Dentist: ______

Phone Number of Previous Dentist: ______

Please Rank the following in the order in which they would keep you from having dental treatment. 1 = Less & 5 = Most.

Fear of Pain	1	2	3	4	5
Cost of Treatment	1	2	3	4	5
Lack of Concern	1	2	3	4	5
Missing Work Time	1	2	3	4	5

The undersigned hereby authorizes Doctor to take xrays, study models, photographs, &/or any other diagnostic aids deemed appropriate by the Doctor, to make a thorough diagnosis of the patient's Dental needs. I also authorize Doctor to perform any &/or all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

PRINT NAME: ______

PATIENT SIGNATURE: ______

DENTIST SIGNATURE: ______

DATE: ______