PINNACLE DENTISTRY
-CO SPRINGS-

Patient Name _____

What is the reason for your visit today?_____

Date of last Dental Visit _____ **Last Dental Cleaning**_____ **Last Full Mouth X-Rays** _____

What was done at your last dental visit?_____

Previous Dentist's name? _____ Reason for leaving?_____

Address_____ City_____ State_____ Phone _____

How often do you have dental examinations? _____ How often do you brush?_____

What other dental aids do you use (Interplak, toothpick, etc.)_____ How often do you floss?_____

Do you have any dental problems now? Yes ☐ No ☐

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes ☐	No ☐
Sweets?	Yes ☐	No ☐
Biting or Chewing?	Yes ☐	No ☐
Have you noticed any mouth odors or bad tastes?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or	Yes ☐	No ☐
any other lesions?	Yes ☐	No ☐

Do your gums bleed or hurt? Yes ☐ No ☐

Have your parents experienced gum disase or tooth loss?	Yes ☐	No ☐
Have you noticed any loose teeth or change in your bite?	Yes ☐	No ☐
Does food tend to become caught in between your teeth?	Yes ☐	No ☐

If yes, where?_____

Do You:

Clench or grind your teeth while awake or sleep?	Yes ☐	No ☐
Bite your lips or cheeks regularly?	Yes ☐	No ☐
Hold foreign objects with your teeth?	Yes ☐	No ☐
(pencils, pipe, pins, nails, fingernails)	Yes ☐	No ☐
Mouth breathe while awake or asleep?	Yes ☐	No ☐
Have tired jaws, especially in the morning?	Yes ☐	No ☐
Smoke/Chew tobacco?	Yes ☐	No ☐

Have you ever had:

Orthodontic treatment?	Yes ☐	No ☐
Oral Surgery?	Yes ☐	No ☐
Periodontal treatment?	Yes ☐	No ☐
Your teeth ground or the bite adjusted?	Yes ☐	No ☐
A bite plate or mouth guard?	Yes ☐	No ☐
A serious injury to the mouth or head?	Yes ☐	No ☐

If so, please describe, including cause

_____

Have you experienced:

Clicking or popping of the jaw?	Yes ☐	No ☐
Pain? (joint, ear, side of face)	Yes ☐	No ☐
Difficulty in opening or closing the mouth?	Yes ☐	No ☐
Difficulty in chewing on either side of the mouth?	Yes ☐	No ☐
Headaches, neck aches or shoulder aches?	Yes ☐	No ☐
Sore muscles (neck, shoulders)?	Yes ☐	No ☐

Are you satisfied with your teeth's appearance?	Yes ☐	No ☐
Would you like to keep all of your teeth your whole life?	Yes ☐	No ☐
Do you feel nervous about having dental treatment?	Yes ☐	No ☐

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes ☐	No ☐

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

If yes, please describe: _____

_____

_____