Dental
Professionals

Hoffman Estates Dental Professionals

Tell us the reason for today's visit. ________________

Tell us your dental interest:

- Are you interested in orthodontic treatment? Y. N.
- Are you interested in teeth whitening? Y. N.
- Are you interested in implant treatment? Y. N.
- Do you have any other dental concerns?

  ____

Tell us about your last dental visit:

- When was your last dental check-up? ________months/ years ago.
- Previous dentist's information:(may be necessary to obtain previous records)

  Name:

  Phone:

  Address:

Dental History

Put a circle on Y for "yes" and on N for "no" to indicate if you have had any of the following:

- Loose teeth or broken fillings Y. N.
- Food collection between the teeth Y. N. If yes, where________
- Foreign objects Y. N. If yes, what is it________
- Sensitivity to cold Y. N.
- Sensitivity to heat Y. N.
- Sensitivity to sweets Y. N.
- Sensitivity when biting Y. N.
- Bad breath Y. N.

  Are you interested in anti-bacterial mouth rinse products? Y. N.

- Cigarette, pipe or cigar smoking Y. N.
- Dry mouth Y. N.
- Are you currently under periodontal treatment at specialist's office? Y. N.

  If yes, at where?________________

- Bleeding gums Y. N.

  If yes, how long have you had bleeding gums? ________

- Gum swollen or tender Y. N.
- Blisters on lips or month Y. N.
- Burning sensation on tongue Y. N.
- Clicking or popping jaw Y. N.
- Have you had a head injury? Y. N. If yes, when________
- Fingernail biting Y. N.
- Grinding teeth Y. N.

  Are you interested in night guard? Y. N.

- Lip or cheek biting Y. N.
- Mouth breathing Y. N.
- Have you received orthodontic treatment before? Y. N. If yes, when ________
- Jaw pain or tiredness Y. N.
- Pain around the ear Y. N.
- Pain while brushing Y. N.
- Sores or growths in your mouth Y. N.
- Any other dental conditions not listed? Y. N.

  If yes, ________________

- How often do you floss? ________
- How often do you brush? ________