

3620 S. BRISTOL ST. • STE 304 • SANTA ANA, CA 92704 P 714.439.9800 • F 714.439.9819 • E BCDENTALHEALTH@GMAIL.COM

INITIAL CLINICAL EXAMINATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE: PATIENT ANME: PATIENT ACCOUNT NO: INITIAL CONCERN: DATE OF LAST DENTAL: VISIT: CLEANING: FULL MOUTH SERIES X-RAYS: 1. Do you have any dental problems now? 2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Personal Series of Sweets? Personal Treatment (Braces) Personal Treatment (Gum Surgery) Personal Treatment (Gum Surgery) Personal Night Guard or other Appliances Personal Series of Sweets? Personal Series of Sweets of Swee		•					
PATIENT ACCOUNT NO.: INITIAL CONCERN: DATE OF LAST DENTAL: VISIT: CLEANING: FULL MOUTH SERIES X-RAYS: 1. Do you have any dental problems now? 2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Biting or Chewing? - Orthodontic Treatment (Braces) - Periodontal Treatment (Gum Surgery) - Worn a Night Guard or other Appliances - Wes No - Worn a Night Guard or other Appliances - Wes No 5. Does food tend to get caught between your teeth? - Do you suffer from pain and / or swelling of the gums? - Do your gums often bleed when you brush your teeth? - Clicking of the Jaw - Pain (joint, ear, side of face)? - Pain (joint, ear, side of face)? - Pein On the Jaw - Pain (joint, ear, side of face)? - Pein On the Jaw - Pain (joint, ear, side of face)? - Pes No - Hold foreign object with your teeth, saleep or awake? - Bite your lips or cheeks regularly? - Yes No - Hold foreign object with your teeth, saleep?							
INITIAL CONCERN: DATE OF LAST DENTAL: VISIT: CLEANING: FULL MOUTH SERIES X-RAYS: 1. Do you have any dental problems now? Yes No 2. Are any of your teeth sensitive to: Hot or Cold? Yes No 3. Have you ever had? - Orthodontic Treatment (Braces) Yes No - Periodontal Treatment (Gum Surgery) Yes No - Wom a Night Guard or other Appliances Yes No - Wom a Night Guard or other Appliances Yes No - Have you noticed any loosening of your teeth? Yes No 5. Does food tend to get caught between your teeth? Yes No 7. Do you suffer from pain and / or swelling of the gums? Yes No 8. Have you repressed when you brush your teeth? Yes No 9. Have you experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Pain (joint, ear, side of face)? Yes No - Pain (joint, ear, side of face)? Yes No - Clench or grind your teeth while asleep or awake? Yes No - Bite your lips or cheeks regularly? Yes No - Bite your lips or cheeks regularly? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No - Bite your lips or cheeks regularly? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No - Bite your lips or cheeks regularly? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No - Bite your lips or cheeks regularly? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No - Hold foreign object with your teeth, Such as pens, pipes, pencils, nails? Yes No				WISHES TO B	E CALLED:		
DATE OF LAST DENTAL: VISIT: CLEANING: FULL MOUTH SERIES X-RAYS: 1. Do you have any dental problems now?							
1. Do you have any dental problems now? 2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Yes No Biting or Chewing? Yes No Biting or Chewing? Yes No 3. Have you ever had? - Orthodontic Treatment (Braces) Yes No - Periodontal Treatment (Gum Surgery) Yes No - Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your A Night Guard or other Appliances Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Jour Jour Jour Jour Jour Jour J	INITIAL CONCERN:						
1. Do you have any dental problems now? 2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Yes No Biting or Chewing? Yes No Biting or Chewing? Yes No 3. Have you ever had? - Orthodontic Treatment (Braces) Yes No - Periodontal Treatment (Gum Surgery) Yes No - Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your A Night Guard or other Appliances Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Jour Teeth Ground or the Bite Adjusted Yes No - Your Jour Jour Jour Jour Jour Jour Jour J		1					
2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Biting or Chewing? 2. Orthodontic Treatment (Braces) Periodontal Treatment (Gum Surgery) Wes No - Periodontal Treatment (Gum Surgery) Wes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Wes No Yes No Yes No - Your Jeeth Ground or the Bite Adjusted Yes No Yes No 1. Do your gums often bleed when you treeth? Periodontal treatment (Gum Surgery) Yes No - Do your gums often bleed when you brush your teeth? Periodontal treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often to get caught between your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Difficulty opening or closing your jaw? Yes No 10. What habits do you have: Clench or grind your teeth while asleep or awake? Pain (joint, ear, side of face)? Yes No Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Periodontal Treatment (Brace) Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No	DATE OF LAST DENTAL: VISIT:	CLEA	ANING:		FULL MOUTH SERIES X-RAYS:		
2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Biting or Chewing? 2. Orthodontic Treatment (Braces) Periodontal Treatment (Gum Surgery) Wes No - Periodontal Treatment (Gum Surgery) Wes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Wes No Yes No Yes No - Your Jeeth Ground or the Bite Adjusted Yes No Yes No 1. Do your gums often bleed when you treeth? Periodontal treatment (Gum Surgery) Yes No - Do your gums often bleed when you brush your teeth? Periodontal treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often to get caught between your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Difficulty opening or closing your jaw? Yes No 10. What habits do you have: Clench or grind your teeth while asleep or awake? Pain (joint, ear, side of face)? Yes No Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Periodontal Treatment (Brace) Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No							
2. Are any of your teeth sensitive to: Hot or Cold? Sweets? Biting or Chewing? 2. Orthodontic Treatment (Braces) Periodontal Treatment (Gum Surgery) Wes No - Periodontal Treatment (Gum Surgery) Wes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Wes No Yes No Yes No - Your Jeeth Ground or the Bite Adjusted Yes No Yes No 1. Do your gums often bleed when you treeth? Periodontal treatment (Gum Surgery) Yes No - Do your gums often bleed when you brush your teeth? Periodontal treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often to get caught between your teeth? Periodontal Treatment (Gum Surgery) Yes No Do your gums often bleed when you brush your teeth? Periodontal Treatment (Gum Surgery) Yes No Difficulty opening or closing your jaw? Yes No 10. What habits do you have: Clench or grind your teeth while asleep or awake? Pain (joint, ear, side of face)? Yes No Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Periodontal Treatment (Brace) Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No Houth breath while awake or asleep? Yes No Yes No	Do you have any dental problems now?					Yes	No
Biting or Chewing? Yes No 3. Have you ever had? - Orthodontic Treatment (Braces) Yes No - Periodontal Treatment (Gum Surgery) Yes No - Worn a Night Guard or other Appliances Yes No 4. Have you noticed any loosening of your teeth? Yes No 5. Does food tend to get caught between your teeth? Yes No 6. Do you suffer from pain and / or swelling of the gums? Yes No 7. Do your gums often bleed when you brush your teeth? Yes No 8. Have your parents experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Pain (joint, ear, side of face)? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Yes No - Bite your lips or cheeks regularly? Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No						Yes	No
3. Have you ever had? - Orthodontic Treatment (Braces)	, ,		Sweets	?		Yes	No
- Orthodontic Treatment (Braces) Yes No - Oral Surgery Yes No - Periodontal Treatment (Gum Surgery) Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Your Teeth Ground or the Bite Adjusted Yes No - Pain (Joint, ear, side of face)? Yes No - Difficulty opening or closing your jaw? Yes No - Difficulty opening or Closing your jaw? Yes No - Difficulty chewing? Yes No - Difficulty chewing? Yes No - Difficulty chewing? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? - Yes No - Mouth breath while awake or asleep? Yes No - Mouth breath while awake or asleep? Yes No - Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? - Yes No - Mouth breath while awake or asleep? Yes No - Yes No - Mouth breath while awake or asleep? Yes No - Yes No - Hold breath while awake or asleep? Yes No - Yes			Biting o	or Chewing?		Yes	No
- Periodontal Treatment (Gum Surgery) Yes No - Worn a Night Guard or other Appliances Yes No 4. Have you noticed any loosening of your teeth?	3. Have you ever had?						
- Worn a Night Guard or other Appliances Yes No 4. Have you noticed any loosening of your teeth? Yes No 5. Does food tend to get caught between your teeth? Yes No 6. Do you suffer from pain and / or swelling of the gums? Yes No 7. Do your gums often bleed when you brush your teeth? Yes No 8. Have you parents experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Difficulty opening or closing your jaw? Yes No - Pain (joint, ear, side of face)? Yes No - Difficulty chewing? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No 11. Do you feel nervous about dental treatment? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No	- Orthodontic Treatment (Braces)	Yes	No	- Oral Surgery		Yes	No
4. Have you noticed any loosening of your teeth? 5. Does food tend to get caught between your teeth? 6. Do you suffer from pain and / or swelling of the gums? 7. Do your gums often bleed when you brush your teeth? 8. Have your parents experienced gum disease? 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw - Pain (joint, ear, side of face)? - Clench or grind your teeth while asleep or awake? - Bite your lips or cheeks regularly? Yes No 10. Do you feel nervous about dental treatment? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No Yes No Yes No - Difficulty opening or closing your jaw? Yes No - Difficulty chewing? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No 14. Hove you ever had an upsetting experience in the dental office? Yes No	- Periodontal Treatment (Gum Surgery)	Yes	No	- Your Teeth Grou	and or the Bite Adjusted	Yes	No
5. Does food tend to get caught between your teeth? Yes No 6. Do you suffer from pain and / or swelling of the gums? Yes No 7. Do your gums often bleed when you brush your teeth? Yes No 8. Have your parents experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Pain (joint, ear, side of face)? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Seite your lips or cheeks regularly? Yes No - Mouth breath while awake or asleep? Yes No 11. Do you feel nervous about dental treatment? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No	- Worn a Night Guard or other Appliances	Yes	No	-			
6. Do you suffer from pain and / or swelling of the gums? 7. Do your gums often bleed when you brush your teeth? 8. Have your parents experienced gum disease? 9. Have you experienced the following problem of the jaw? 1. Clicking of the Jaw	4. Have you noticed any loosening of your teeth?			<u></u>		Yes	No
6. Do you suffer from pain and / or swelling of the gums? 7. Do your gums often bleed when you brush your teeth? 8. Have your parents experienced gum disease? 9. Have you experienced the following problem of the jaw? 1. Clicking of the Jaw						Yes	No
7. Do your gums often bleed when you brush your teeth? Yes No 8. Have your parents experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Pain (joint, ear, side of face)? Yes No - Difficulty opening or closing your jaw? Yes No - Difficulty chewing? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Such as pens, pipes, pencils, nails? Yes No - Bite your lips or cheeks regularly? Yes No - Mouth breath while awake or asleep? Yes No 11. Do you feel nervous about dental treatment? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No						Yes	No
8. Have your parents experienced gum disease? Yes No 9. Have you experienced the following problem of the jaw? - Clicking of the Jaw Yes No - Pain (joint, ear, side of face)? Yes No - Difficulty opening or closing your jaw? Yes No - Difficulty chewing? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Yes No - Bite your lips or cheeks regularly? Yes No - Mouth breath while awake or asleep? Yes No 11. Do you feel nervous about dental treatment? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No	, , , , , , , , , , , , , , , , , , , ,					Yes	No
9. Have you experienced the following problem of the jaw? - Clicking of the Jaw						Yes	No
- Clicking of the Jaw							
- Pain (joint, ear, side of face)? Yes No - Difficulty chewing? Yes No 10. What habits do you have: - Clench or grind your teeth while asleep or awake? Yes No - Hold foreign object with your teeth, such as pens, pipes, pencils, nails? Yes No 11. Do you feel nervous about dental treatment? Yes No - Mouth breath while awake or asleep? Yes No 12. Have you ever had an upsetting experience in the dental office? Yes No			No	7 - Difficulty openin	a or closing your jaw?	Yes	No
10. What habits do you have: - Clench or grind your teeth while asleep or awake?			No		3, 3,		No
asleep or awake? such as pens, pipes, pencils, nails? Yes No No]	3		
- Bite your lips or cheeks regularly?	<i>5</i> ,	Yes	No	,	, ,	Yes	No
12. Have you ever had an upsetting experience in the dental office?	•	Yes	No			Yes	No
, , , , , , , , , , , , , , , , , , , ,	11. Do you feel nervous about dental treatment?					Yes	No
13. Do you expect to eventually lose your teeth? Yes No	12. Have you ever had an upsetting experience in the dental office?					Yes	No
	13. Do you expect to eventually lose your teeth?					Yes	No
14. Are you dissatisfied with the appearance of your teeth? Yes No	14. Are you dissatisfied with the appearance of your teeth?					Yes	No
15. Is there anything else about having dental treatment that bothers you?	15. Is there anything else about having dental treatment that bothers you?					Yes	No
Explanation:	Explanation:						

Patient Hot Buttons		
Esthetics:	Fear:	
Health:	Pain Concern:	
Prevention:	Money:	
Function:	Time:	
Pain Motivator:	Embarrassment:	
Guilt:	Anger:	
Status:	Frustration:	
Peer Pressure:	Other:	
Other:	Other:	