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INITIAL CLINICAL EXAMINATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE:			
PATIENT NAME:		WISHES TO BE CALLED:	
PATIENT ACCOUNT NO.:			
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
Sweets?	Yes	No
Biting or Chewing?	Yes	No

3. Have you ever had?

- Orthodontic Treatment (Braces)	Yes	No	- Oral Surgery	Yes	No
- Periodontal Treatment (Gum Surgery)	Yes	No	- Your Teeth Ground or the Bite Adjusted	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	- 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
- 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
13. Do you expect to eventually lose 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?	Yes	No

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: