PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
www.greenvalleydentalcare.com

Adult Dental History

Patient Name: _____ DOB: _____

ESTABLISHING (NEW) PATIENTS ONLY

When was the last time you visited a dentist?_____

When was your last cleaning? _____

Name of former Dentist: _____

Reason for leaving:_____

What occurred on your last visit to the dentist (x-rays taken, treatment given or recommended):_____

EXISTING PATIENTS -START FORM HERE

Do you have any concerns with your mouth/teeth? Yes No

If yes, please explain:_____

_____

Are you happy with your smile? Please rate below:

very unhappy 1 2 3 4 5 6 7 8 9 10 very happy

How anxious are you when visiting the dentist?

not at all anxious 1 2 3 4 5 6 7 8 9 10 extremely anxious

How interested are you in the following?

1. Whiter Teeth/Brighter smile:

   not interested 1 2 3 4 5 6 7 8 9 10 very interested

2. Straightening your teeth/bite:

   not interested 1 2 3 4 5 6 7 8 9 10 very interested

3. Addressing bad breath/malodor:

   not interested 1 2 3 4 5 6 7 8 9 10 very interested

4. Receiving an anesthetic reversal agent post-dental treatment (reduces numbness by ½, on average)

   not interested 1 2 3 4 5 6 7 8 9 10 very interested

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Adult Dental History (con't.)

Patient Name: _____ DOB: _____

Have you ever been treated for gum disease? Yes No

Do you have well water? Yes No Is your water fluoridated? Yes No Unsure

Are your teeth sensitive to any of the following (please circle all that apply):

1. hot food or liquids 2. cold foods or liquids

3. sweet foods or liquids 4. pressure when eating/biting

How long after eating or drinking does this sensitivity last? _____

Are you concerned with snoring or sleep apnea? Yes No

Do your gums bleed or cause pain? Yes No

Do you experience dry mouth? Yes No

Do you get occasional canker or cold sores? Yes No

Are there any missing teeth you would like replaced? Yes No

Do you notice yourself biting or clenching your teeth? Yes No

Are you interested in cosmetic teeth enhancements such as tooth gems, or crown "tattoo"? Yes No

Please circle if you experience any of the following with your jaw:

1. popping or clicking noise 2. jaw locks up 3. pain and/or tenderness in jaw muscles

Do you wear a bite (night) guard? Yes No

Are you using any over-the-counter tools for oral care (such as WaterPik®, electric toothbrush, chewing gum for dry mouth symptoms)? Yes No

If yes, please describe: _____

Is there anything else we should know to help provide you with the best care?

_____

Patient Signature:_____ Date:

Dentist Signature:_____ Date: