Welcome to Dr. Pamela Weitzel's Dental Practice

Name of patient_____ Date of Birth_____/_____/_____

Reason for this visit_____

Are you having any dental problems at this time YES / NO? Please describe any problem you are having

_____

How long since your last dental appointment? _____Did you have your teeth cleaned at that time YES / NO?

Were X-Rays taken then YES / NO? What was the date? _____

What was the name of your previous dentist? _____Phone_____

Address of Previous dentist_____

Did you go for regular visits YES / NO? How often did you go? _____ Were you given fluoride YES / NO?

How often do you brush your teeth? _____

How often do you floss? _____ Do your gums bleed or hurt? YES / NO When_____

Have you ever had gum surgery YES /NO What_____

Where_____ When_____

Circle any that apply: are any of your teeth sensitive to: Hot Cold Sweets Pressure

Are any of your teeth: Loose Chipped Cracked Crooked?

Do you clench or grind your teeth? YES / NO if so when _____

Does your jaw click or pop? YES/ NO. Do you get headaches, shoulder or neck aches YES / NO

Have you experienced any pain or soreness in the muscles of your face or around your ears? YES / NO

If so please explain_____

Are you missing any teeth YES / NO? Why? _____ Have you had them replaced? YES / NO?

How were they replaced? _____

How long ago were they replaced? _____ Are you happy with the replacement? YES / NO

If not, why not? _____

Would you like to talk about alternatives? YES / NO If yes please explain_____
Have you ever had a bad dental experience YES / NO

If so please explain_____

Is there anything you are concerned about? YES / NO If yes what_____

Have you ever had any Orthodontic work? _____

DENTAL HISTORY