SPECIALISTS IN IMPLANT DENTISTRY

Dental History

Please describe your current dental health: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

How did you hear of us? Friend/Family: _____ ☐ TV ☐ Newspaper ☐ Seminar

Anxiety Level (please check): ☐ Fearless ☐ Indifferent ☐ Trembling/Anxious

Is this your first consultation regarding dental implants: ☐ YES ☐ NO

Please explain what symptoms or tooth related concerns prompted this visit:

☐ Difficulty Chewing
☐ Pain
☐ Infected Teeth
☐ Facial Swelling
☐ Missing Teeth
☐ Lack of Social Interaction
☐ Dentures/Partials
☐ Bad Breath
☐ Embarrassment
☐ Failing Dental Work
☐ Broken Teeth
☐ Failing Dental Implants
☐ Other

COMMENTS: _____

_____

Have you ever been diagnosed with periodontal disease: ☐ YES ☐ NO
If yes, do you currently have loose teeth: ☐ YES ☐ NO

Please specify what treatment you are most interested in:
☐ Full Mouth ☐ Single Tooth ☐ Upper Teeth/Arch ☐ Lower Teeth/Arch

DENTURES: How long have you worn dentures: _____

What is your chief complaint: ☐ Ill-Fitting/Pain ☐ Difficulty Chewing ☐ Gag Reflex

Other: _____

Shade or mark the area(s) of your mouth that are in pain in the diagram below:

Notes: _____

_____

_____

_____

_____

Signature **Print Name** **Date**