Tell Us About You!

Name:______________________________

Medical Doctor:________________________Last Visit:__________Phone:__________________

Previous Dentist:______________________Last Visit:__________Phone:__________________

1. What can we do to help you today?____

2. Are you apprehensive about dental treatment? Not Very/Somewhat/Very Much

3. Have you had problems with prior dental treatment? Y N

   If Yes, please explain:____

4. Are you in pain now? Y N

   If yes, please explain:____

5. How much would you like to learn about dentistry? How much would you like Dr. Nordlie to tell you about what he is doing during treatment? Nothing at all/A little bit/ Every little detail

6. Are you happy with your smile? Y N

   If not, what would you change?____

7. Are you interested in whitening (bleaching) your teeth? Y N

8. Do you want complete treatment or are you here for a localized problem?_______________

9. Are you interested in Invisalign (clear braces for straightening teeth)? Y N

10. Would you prefer a neck pillow during your dental appointments? Y N

	Yes	No		Yes	No
Do you gag easily?			Do you have pain, clicking or popping in your jaw joint (TMJ)?		
Do you wear dentures?			Do you clench or grind your jaws frequently?		
Does food catch between your teeth?			Does your jaw ever get stuck so that you can't open freely?		
Do your gums bleed easily?			Do you have any jaw symptoms or headaches upon awakening in the morning?		
Do your gums bleed while flossing?			Have you had a blow to the jaw (trauma)?		
Have you ever noticed slow-healing sores in or about your mouth?			Do you have earaches or pain in front of the ears?		
Are your teeth sensitive?			Are you a habitual gum chewer?		
Do you have dry mouth?			Are you aware of an uncomfortable bite?		
How often do you brush: __________ times per day			Have you ever been treated for Temporomandibular Joint Disorder (TMD)?		
How often do you floss? __________ times per day					
Do you take fluoride supplements?					