

# BOLLINGER CANYON DENTAL WELCOMES YOU

## Dental History

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Reason for leaving last Dentist \_\_\_\_\_

Our office is like no other office dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. You probably never thought of these issues. Please check what best expresses how you feel about the following questions:

Are you having any areas of concern? \_\_\_\_\_

Tell us in your opinion, what you think the present state of the health of your mouth is? \_\_\_\_\_

How do you feel about the appearance of your teeth and smile? \_\_\_\_\_

What do you already know about our office and what are your expectations? \_\_\_\_\_

How healthy do you want us to get your mouth?

"Don't really care"  Average  The best it can be

Should you need treatment, at what point should we address it? When:

My tooth hurts or breaks  Something gets worse  Something isn't ideal

What quality of dentistry do you want us to recommend?

Just patch it  Average  The best it can be

We have the ability to look at your mouth from 3 different perspectives. What combination of these would you prefer?

As a general dentist  As a cosmetic dentist  As a functional dentist

What kind of a good dental experience would develop the trust for us to be your dentist?

Has the cost of dental treatment been a concern for you, and how can we help there? \_\_\_\_\_

**Check  if you have any of the following:**

- |                          |                                       |                          |                                   |
|--------------------------|---------------------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | Bad Breath                            | <input type="checkbox"/> | Clenching/Bruxing                 |
| <input type="checkbox"/> | Bleeding gums                         | <input type="checkbox"/> | Jaw pain/popping/clicking         |
| <input type="checkbox"/> | Gum treatment                         | <input type="checkbox"/> | Limited Opening                   |
| <input type="checkbox"/> | Sensitivity to hot/cold foods/chewing | <input type="checkbox"/> | Ringling ears/dizziness (vertigo) |
| <input type="checkbox"/> | Broken fillings/food impaction        | <input type="checkbox"/> | Facial pain/paralysis             |
| <input type="checkbox"/> | Loose teeth                           | <input type="checkbox"/> | Difficulty in swallowing/chewing  |
| <input type="checkbox"/> | Headaches/neck aches                  | <input type="checkbox"/> | Tingling in arms/fingers          |

**How often do you brush and floss?** \_\_\_\_\_

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby consent my dentist to take any necessary X-rays, models, and photographs and perform a thorough diagnosis and treatment as needed. I also consent my dentist to perform all recommended treatment and use of appropriate medication and therapy indicated for such treatment.*

Patient/Parent/Legal Guardian

Date