DENTAL HISTORY

How can we help you? _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? **Yes [ ]** **No [ ]**

On a scale of 1-10, 10 being the highest, what priority do you give your teeth? _____

Do you have any pain in any part of your mouth or in any tooth while biting or chewing? **Yes [ ]** **No [ ]**

Do your gums feel tender or swollen? **Yes [ ]** **No [ ]**

Do you usually have many cavities? **Yes [ ]** **No [ ]**

Do you lose or break fillings? **Yes [ ]** **No [ ]**

Are you familiar with the term “preventive dentistry”? **Yes [ ]** **No [ ]**

Are you happy with the appearance of your teeth? **Yes [ ]** **No [ ]**

Have you ever had problems with your TMJ? **Yes [ ]** **No [ ]**

Do you ever have pain, clicking, popping or grating sounds from your jaw joints? **Yes [ ]** **No [ ]**

Do you become easily fatigued? **Yes [ ]** **No [ ]**

Do you snore or have you been told you do? **Yes [ ]** **No [ ]**

Have you been diagnosed or treated for a sleep disorder? **Yes [ ]** **No [ ]**

Have any family members been diagnosed with a sleep disorder? **Yes [ ]** **No [ ]**

What is the one thing you liked least about any former dentist or office? _____

_____

What is the one thing that you like most about any former dentist or office? _____

_____

Thank you for taking the time to complete these questions.

My staff and I look forward to taking great care of your dental needs and concerns!

Kelli L. Brady, DDS
180 Old Tappan Rd, Bldg 6
Old Tappan, NJ 07675
Phone 201.768.5553
Fax 201.768.7601