URGENT CARE QUESTIONNAIRE

In order for us to provide the best diagnosis and treatment possible, please answer all questions to the best of your ability. Thank you.

On a scale of **1-10**, how important is your dental health to you? (1="Not very important," 10-"Extremely important.")			1-2-3-4-5-6-7-8-9-10	
On a scale of **1-10**, how would you rate your current dental health? (1="Very poor," 10="Excellent.")			1-2-3-4-5-6-7-8-9-10	
Who may we thank for referring you?			*Years*	*Months*
When was your last dental visit?				
Area of concern (please circle):	Upper Right	Lower Right	Upper Left	Lower Left
What is your immediate or main concern?				

PERSONAL HISTORY		
Are you fearful of dental treatment?	YES	NO
If "yes," how fearful on a scale of 1(somewhat) to 10 (extremely)?	1-2-3-4-5-6-7-8-9-10	
Have you ever had trouble getting numb, or reactions to local anesthetic?	YES	NO
Do you experience spontaneous pain (pain for no apparent cause or reason)?	YES	NO
On a scale 1-10, what is your current pain level? (1="Slightly sensitive," 10="Extremely painful.")	1-2-3-4-5-6-7-8-9-10	
GUM AND BONE		
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	YES	NO
Do your gums bleed or are they painful when brushing, flossing or eating?	YES	NO
Do you have swelling inside or outside of your mouth?	YES	NO
TOOTH STRUCTURE		
Do your parents or siblings have "bad teeth"?	YES	NO
Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing food?	YES	NO
Are any teeth currently sensitive to hot, cold, biting, brushing or sweets (circle all that apply)?	YES	NO
Do you have a cracked filling, broken, chipped or cracked tooth (circle all that apply)?	YES	NO
BITE, CHEWING AND JAW JOINT		
Do you have problems with your jaw joint: pain, sounds, limited opening, locking, popping (circle all that apply)?	YES	NO
Is today's problem affecting your ability to eat or chew normally?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you have problems sleeping (i.e. restlessness), wake up with pain, headache or an awareness of your teeth?	YES	NO
Do you or have you ever worn a bite appliance (Niteguard, Splint)?	YES	NO
SMILE CHARACTERISTICS		
Have you felt unhappy, uncomfortable or self-conscious about the appearance of your teeth?	YES	NO
Is there anything about the appearance of your teeth that you would like to change?	YES	NO
If "yes," what would you like to change?		

Patient's Name:_____

Patient's Signature:_____

Date:_____

Doctor's Signature:_____