O'LEARY DENTAL OFFICE

Kevin S. O'Leary, D.D.S.

DENTAL HISTORY NEW PATIENT EVALUATION

PATIENT'S NAME: _____ **DOB:** _____

DENTAL CARE

Are you currently under a Dentist's Care**?** **YES / NO** If yes, please explain: _____

Name of the DENTIST that provided care: _____

Date of your last dental visit: _____ Date of last dental X-rays: 6 mo. / 1 yr / _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What other dental aids do you use? _____

(examples: Electric toothbrush, flosser, tooth pick, etc…..)

Do you wear dentures? **YES / NO** **PARTIALS / FULL**

Are you happy with your dentures? **YES / NO** Why?_____

PLACE A CHECK MARK NEXT TO THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

- □ Gum Disease
- □ Decay
- □ Bad Breath
- □ Cold sores, blisters or oral lesions
- □ Prolonged bleeding either from a cut or dental procedure
- □ Headaches
- □ Neck pain
- □ Gums feel tender
- □ Discolored teeth
- □ Loose teeth
- □ Tired jaws, especially in the morning
- □ Broken Jaw
- □ Difficulty getting numb
- □ Ear aches
- □ Bleeding gums
- □ Gums feel tender or irritated

PLACE A CHECK MARK NEXT TO THE DENTAL TREATMENT WHICH YOU HAVE HAD:

- □ Orthodontic Treatment (Braces)
- □ Teeth Extraction
- □ Missing Teeth with No Replacement
- □ Periodontal Treatment (Treatment for gum disease, gum regenerative procedures, gum surgery)
- □ Endodontic Treatment (Root Canals)
- □ Bite Adjustment
- □ General Anesthesia
- □ Cortisone Injections into the joints

REVISED 07.15.16 JD

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DENTAL HISTORY NEW PATIENT EVALUATION

PATIENT'S NAME: _____ **DOB:** _____

PLACE A CHECK MARK NEXT TO THE HABITS YOU FIND YOURSELF DOING:

- □ Clench or grind your teeth
- □ Bite your cheeks
- □ Bite your nails
- □ Chew Gum often
- □ Other Oral Habits (ie: pencil biting)
- □ Bite on your front teeth first
- □ Get food caught between your teeth

PLACE A CHECK MARK NEXT TO THE THINGS YOUR TEETH ARE SENSITIVE TO:

□ Hot □ Cold □ Sweets □ Biting and Chewing □ No Sensitivity

DENTAL CARE ASSESSMENT : Please answer the questions below by CIRCLING your answer.

Are you happy with the general appearance of your teeth? YES / NO

Do you want your smile to look better or different in any way? YES / NO

How healthy would you like your mouth to be if you were to complete dental care here?

I do not really care ; Average ; Ideal

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

When my tooth hurts or breaks ; When something worsens ; As soon as problem is identified

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What quality of Dentistry do you want to receive?

A patch or quick repair ; Average ; Ideal

Rank in order 1 – 4 what would keep you from having dental treatment?

(#1 being the most important)

#____Fear ; #___Cost of treatment ; #___Missing work ; #___Lack of Concern for teeth

INJURIES TO THE MOUTH/ JAW/ TEETH

Have you had any accidents or injuries? (includes: sports, slips, falls or auto) **YES / NO**

If yes, an approximate date of when it happened: _____

A brief summary of what happened:_____

If dental treatment was performed, please provide a brief summary of what was done:

X_____ _____

Patient Signature or Guardian's Signature **Date**

REVISED 07.15.16 JD