GETTING TO KNOW YOU
Comprehensive Exam

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NAME: _____DATE: _____

What name would you like us to call you? _____

Please describe the reason for your consultation today:

_____

_____

_____

_____

How long has this been going on and what other events apply to today's visit?

_____

_____

Why have you decided to deal with this now?

_____

Have you consulted with any other dentist about this? ☐ Yes ☐ No If yes, what was discussed or done?

_____

_____

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you:

Have gum disease (gingivitis)	**☐ Yes ☐ No**	**Lip or cheek biting**	**☐ Yes ☐ No**
Grind your teeth	**☐ Yes ☐ No**	**Loose or broken teeth or fillings**	**☐ Yes ☐ No**
Clicking or popping jaw	**☐ Yes ☐ No**	**Food collection between teeth**	**☐ Yes ☐ No**
Jaw Pain or tiredness	**☐ Yes ☐ No**	**Sores, blisters or growths**	**☐ Yes ☐ No**
Pain around ear	**☐ Yes ☐ No**	**Bad Breath**	**☐ Yes ☐ No**

Sensitivity to: ☐ cold ☐ heat ☐ sweets ☐ when biting or chewing

What are your priorities and what would you like to see done now?

_____

_____

_____