

WELCOME TO OUR OFFICE

We are a health centered dental practice. Thus, we are concerned with your total well-being, not just your oral health; an essential part of our approach is a thorough health story. Please fill out the dental questionnaire below, along with the additional medical questionnaire, completely- even if some of the questions may not seem relevant to your dental health. Thank you.

PATIENT NAME: _____

PATIENT BIRTHDATE: _____

What are your hobbies or special interests? (i.e.: sports, self improvement, education)

Do you need a referral for a physician or specialist? YES NO

Reason for this dental visit _____

Date of last dental visit _____ What was done at that time? _____

Have you ever been treated by a periodontist, orthodontist, or endodontist? YES NO

If yes, please explain _____

Date of last dental x-rays _____

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

If there was anything you could change about your smile, what would it be?

Do you like the Media Image of "Perfectly Straight, White" looking teeth, or are you content with "Healthy, Clean, Natural" looking teeth?

_____ Media Image _____ Natural Looking

History of esthetic change

Have you noticed any of the following?

Teeth tender to chew on	YES NO	Swelling or lumps in mouth	YES NO
Recurring sore in or around the mouth	YES NO	Loose teeth	YES NO
Discomfort in face, head, neck or jaw	YES NO	Jaw clicking or popping	YES NO
Food caught between your teeth	YES NO	Bleeding or sore gums	YES NO
Sensitivity to sweets, hot or cold	YES NO	Do you need nitrous oxide?	YES NO

Have you had any problems with previous dental treatment? YES NO

If so, please explain _____

Dental Office of Whitney R. Johnson, D.D.S.
DENTAL INFORMATION