PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
www.greenvalleydentalcare.com

Adult Dental History

Patient Name: _____ **DOB:** _____

When was the last time you visited a dentist?_____

When was your last cleaning? _____

Name of former Dentist: _____ Contact information for former dentist (if available): _____

Reason for leaving:_____

What occurred on your last visit to the dentist (x-rays taken, treatment given or recommended):

_____

Do you have any concerns with your mouth/teeth? **Yes** **No**

If yes, please explain:_____

_____

Are you happy with your smile? Please rate below:

very unhappy 1 2 3 4 5 6 7 8 9 10 **very happy**

How anxious are you when visiting the dentist?

not at all anxious 1 2 3 4 5 6 7 8 9 10 **extremely anxious**

How interested are you in the following?

1. Whiter Teeth/Brighter smile:

   not interested 1 2 3 4 5 6 7 8 9 10 **very interested**

2. Straightening your teeth/bite:

   not interested 1 2 3 4 5 6 7 8 9 10 **very interested**

3. Addressing bad breath/malodor:

   not interested 1 2 3 4 5 6 7 8 9 10 **very interested**

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Adult Dental History (con't.)

Patient Name: _____ **DOB:** _____

Have you ever been treated for gum disease? **Yes** **No**

Do you have well water? **Yes** **No** Is your water fluoridated? **Yes** **No** **Unsure**

Are your teeth sensitive to any of the following (please circle all that apply):

1. hot food or liquids **2.** cold foods or liquids

3. sweet foods or liquids **4.** pressure when eating/biting

How long after eating or drinking does this sensitivity last? _____

Are you concerned with snoring or sleep apnea? **Yes** **No**

Do your gums bleed or cause pain? **Yes** **No**

Do you experience dry mouth? **Yes** **No**

Do you get occasional canker or cold sores? **Yes** **No**

Are there any missing teeth you would like replaced? **Yes** **No**

Do you notice yourself biting or clenching your teeth? **Yes** **No**

Please circle if you experience any of the following with your jaw:

1. popping or clicking noise **2.** jaw locks up

3. pain and/or tenderness in jaw muscles

Do you wear a bite (night) guard? **Yes** **No**

Is there anything else we should know to help provide you with the best care?

_____

_____

Patient Signature:_____ Date: _____

Dentist Signature:_____ Date: _____