JOSEPH J. KURTIS, DMD
fine restorative and cosmetic dentistry

Patient Name:_____ ***Date:***_____

Dental History

Thank you for considering our practice! Please describe any dental problems or concerns you are having at this time: _____
_____

Do you have any pain when you chew or bite?_____If yes, where? When? _____
_____

Do you have any teeth that are sensitive to hot, cold, or sweets? _____ If yes, when? _____
_____

How often do you have your teeth examined and cleaned?_____
When was the last time you had a complete set of dental x-rays?_____

Have you needed much dental work in the past?_____ If yes, please briefly describe what has been done:_____
_____

How do you feel about the *quality* of dental care you have received up to this point?
_____

Are you missing any teeth?_____ If yes, do you regret losing any of them?_____

Have you ever worn braces?_____ If yes, when?_____ For how long?_____

Does your bite feel comfortable?_____
Can you chew as well as you would like to?_____

Are you satisfied with the appearance of your teeth? _____If no, what is it that you do not like about your teeth / smile?_____
_____
What is your typical daily oral hygiene routine?_____
_____
Do your gums bleed when you brush your teeth? _____
Have you ever been *told* that you have gum disease? _____
Have you ever been *treated* for gum disease? _____

Did / do your parents have gum disease? _____
Did / do your parents wear dentures? _____

How often do you suffer from bad breath? ____ Never ____ Seldom ____Often
Do you use gum, breath mints, or cough drops? ____ Never ____ Seldom ____Often
How often do you snack between meals? ____ Never ____ Seldom ____Often
Do your jaw joints ever click, pop, hurt or lock-up?_____

(continued to back)

Have you ever been treated for "TMJ"? _____

Would you consider your daily diet to be: _____ Healthy _____ Good _____ Poor

Do you exercise regularly? ____No ___ Yes If yes, what do you typically do? _____

Do you sleep well at night? ___ No ___ Yes Do you awaken well rested? ___No ___Yes

Do you use or have recently used tobacco products? ____No ____Yes

How much of a priority is it for you to keep your natural teeth over your lifetime?

(Circle) **Very high priority somewhat high not sure yet low priority**

How would you rate your *current* dental health?

Perfect			**Good**		**Fair**			**Poor**	**Hopeless**
(Circle)	10	9	8	7	6	5	4	3	2	1

How do you feel about visiting our office today?
(Circle) Excited Hopeful Concerned Afraid Other:_____

What concerns you *most* about visiting the dentist?_____
_____

What elements of dental care are your top priorities at this time?

Please Check

____ **Clean your teeth**
____ **Identify and address *current* problems**
____ **Work with you to *create long-range strategies* which can create and maintain the health of your teeth and smile over your lifetime.**
____ **Work with you to identify ways to *improve the appearance of your teeth/smile.***

Optional

We know that excessive stress can negatively influence all aspects of our health. What do you feel are the biggest sources of stress you are facing these days? _____
_____

Is there anything else that you would like us to know or focus on at this first visit?_____
_____
_____

_____ _____
Patient Signature Date