YOUR DENTAL HISTORY

Name_____

How did you first hear about us? _____

Why did you leave your last Dentist? _____

If you had a magic wand, what would you do to your teeth?
Whiter?____yes____no Straighter?____yes____no

What's the worst thing that ever happened to you in a dental office?
_____

What's the best thing that ever happened to you in a dental office?
_____

Are you having any discomfort at this time? _____

How long has it been since your last dental visit? _____

What was done? _____

When was your last set of x-rays? _____

Do you feel you have bad breath? ___Yes ___No
Does food get caught between your teeth? ___Yes ___No
Do your gums bleed? ___Yes ___No
Do you clench your teeth? ___Yes ___No
Do you snore or have problems with sleep apnea? ___Yes ___No

Are you available short notice?___Yes___No
What is your preferred time and day for appointment?
Time_____
Day_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand by signing below that I give my consent for the Doctors and Providers of Northwoods Dental to provide preliminary treatment to me. I understand that the Doctor's full diagnosis will be presented to me before treatment is begun.

_____

Signature of patient, parent, or guardian_____ Date_____