PHILLEY
DENTISTRY

Patient's name:____________________________________ **Date:**____________

What is the reason for today's visit? ____

When was your last dental appointment?

____

Do you have dental related discomfort or pain? ____

Hot? Cold? Pressure? Headaches?

Do you have dental anxiety?**Yes** **No**

How would you rate your dental phobia?

1 2 3 4 5 6 7 8 9 10

No fear **Extreme fear**

Do you have any special requests regarding dental visits :

Headphones

Nitrous Oxide

Oral Sedative

IV Sedation

How often do you brush? **1x**/day **2x**/day **3x**/day

How often do you floss? **Daily** **Weekly** **Monthly** **Never**

YES **NO**

Do you have any areas where food collects between teeth? If so where? ________________________

Do your gums bleed while brushing or flossing?

Do you clinch or grind your teeth?

Do you have jaw pain or discomfort?