INITIAL CLINICAL EXAMINATION

Date:_____

PATIENT NAME	PATIENT ACCOUNT NO.

INITIAL CONCERN:_____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST FULL MOUTH SERIES X-RAYS

1. Are you having pain at this time? ..... ☐Yes ☐No
2. Have you ever had:
   a. Orthodontic Treatment? ..... ☐Yes ☐No
   b. Oral Surgery? ..... ☐Yes ☐No
   c. Periodontal Treatment? ..... ☐Yes ☐No
   d. Your teeth ground or the bite adjusted? ..... ☐Yes ☐No
   e. Or worn a bite plate or other appliance? ..... ☐Yes ☐No
3. Have you noticed any loosening of your teeth? .... ☐Yes ☐No
4. Does food tend to become caught between your teeth? ..... ☐Yes ☐No
5. Do you suffer from pain and/or swelling of your gums? ..... ☐Yes ☐No
6. Do your gums often bleed when you brush your teeth? ..... ☐Yes ☐No
7. Is there history of gum disease in your family? ..... ☐Yes ☐No
8. PROBLEMS OF THE JAW. Have you experienced:
   a. Clicking of the jaw? ..... ☐Yes ☐No
   b. Pain (joint, ear, side of face)? ..... ☐Yes ☐No
   c. Difficulty in opening or closing? ..... ☐Yes ☐No
   d. Difficulty in chewing? ..... ☐Yes ☐No
9. Does your mouth feel dry at times? ..... ☐Yes ☐No
10. HABITS. Do you:
    a. Clench or grind your teeth while awake or asleep? ..... ☐Yes ☐No
    b. Bite your lips or cheeks regularly? ..... ☐Yes ☐No
    c. Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)? ☐Yes ☐No
    d. Mouth breath while awake or asleep? ..... ☐Yes ☐No
11. Do you have a burning sensation of the lips, tongue? ..... ☐Yes ☐No
12. Are you aware of bad breath or bad taste in your mouth? ..... ☐Yes ☐No
13. Do you feel very nervous about having dental treatment? ..... ☐Yes ☐No
14. Have you ever had an upsetting experience in a Dental Office? ..... ☐Yes ☐No
15. Is it important to keep your teeth? ..... ☐Yes ☐No
16. Are you dissatisfied with the appearance of your teeth? ..... ☐Yes ☐No
17. Is there anything else about having dental treatment that bothers you? ..... ☐Yes ☐No

    Explanation:_____

    _____
18. If there was one thing you could change with your teeth, what would it be?

    _____

WELCOME TO OUR OFFICE!!

In this office, our philosophy is to add value to the lives of our patients by offering quality treatment and total patient care in a high trust and low fear environment.

To this end, you will be provided with treatment recommendations following a thorough examination and diagnosis. Please note that these recommendations are based on your needs to achieve superior dental health and not on the degree of dental insurance coverage you have.

Following discussion of your treatment plan and associated professional fees, you will be provided with a written estimate for submission to your insurance company to determine the amount of your required treatment which you may expect to be covered.

I understand that the fees for dental treatment may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment which was agreed upon.

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Patient /Parent signature