Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

How long has it been since your last Dental Cleaning?

_____

_____

How Long has it been since you had a Full Mouth Set of Xrays or Panoramic? _____

Who was your previous Dentist?

_____

_____

Has your past dental experiences been Positive? ◯ Yes ◯ No

Are you happy with your teeth and smile? ◯ Yes ◯ No

How would you desribe your Dental Health?

☐ GOOD ☐ FAIR ☐ POOR

Please mark if you have or had any of the following:

☐ Abcess Tooth	☐ Sensitive Teeth	☐ Clenching or Grinding	☐ Jaw Joint Pain	☐ Loose Teeth	☐ Sensitive Gums
☐ Cold Sores	☐ Difficulty Chewing	☐ Bleeding Gums	☐ Gum Disease	☐ Mouth Sores	☐ Dry Mouth
☐ Swelling	☐ Gag Easily	☐ Oral Cancer			

Do you use tobacco products? ◯ Yes ◯ No

Which Kind?

☐ Smoke ☐ Chew ☐ Vape

How Long? _____

Do you have any special concerns regarding your visit today? ◯ Yes ◯ No

I give Dr. Skinner Consent to use Local Anesthetic as needed ◯ Yes ◯ No

I give Dr. Skinner Consent to use Nitrous Oxide per my request ◯ Yes ◯ No

Signature _____ **Date** _____

Response Date: _____