

GETTING TO KNOW YOU

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NAME: _____ DATE: _____

Please describe the focus of your consultation today:

Have you consulted with any other dentist about this? Yes No If yes, what was discussed or done?

When was your last dental visit? _____ Hygiene visit? _____ Diagnostic Records? _____
(models, x-rays, photos)

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you have:

Gum disease (gingivitis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums bleed while brushing/flossing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores, blisters or growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grind your teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use of Mouth Rinse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw Pain or soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coffee, tea, sodas	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	(Circle all that apply)	# _____/day
Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Sensitivity to: cold heat sweets when biting or chewing /Area _____

I hereby authorize Dr. Merriman and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Merriman to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon diagnosis I also authorize Dr. Merriman to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Signature _____ Date _____