Welcome to
Murray Dental Center

Name: _____ Date of birth: _____
Last First Middle

Name of physician: _____
Name City Phone

Name of former dentist: _____
Name City Phone

Dental History

1. What is the reason for your visit today? _____

2. What was the approximate date of your last dental visit? _____

3. How often do you routinely see the dentist and hygienist? _____

4. Please rate in order of importance your primary concerns regarding your dental care.
(*Rank in order of importance: most important = #1, least important = #4)*

____Preventative dental health care ____Cost and affordability
____Excellence and quality of service ____Other_____

5. What is your comfort level at the dentist office? *(Circle one: Very comfortable = #1, uncomfortable = #5)*
1 2 3 4 5

6. If you could change something about your smile, what would it be? _____
_____

Please check Yes or No for the following questions	Yes	No
7. Do you have any pain or sensitivity in your teeth or gums?		
8. Do you have any cracked, chipped, or rough teeth?		
9. Do you have any sores, swelling or blisters on your gums, cheeks, or lips?		
10. Have you ever had a traumatic injury to your face or jaw?		
11. Have you ever had orthodontic treatment?		
12. Have you ever been treated for temporomandibular joint (TMJ) problems?		
13. Are you aware, or have you ever been told, that you clench or grind your teeth?		
14. Have you ever been to an Oral Surgeon?		
15. Have you ever been treated for periodontal (gum) disease?		
16. Have you ever had an unusual reaction to dental anesthesia?		
17. Have you ever been told to take antibiotics prior to dental treatment?		