OLD TOWN DENTISTRY

Frinet M. Kasper, DDS

PATIENT'S NAME: ________________________________ **DATE:** ____________________

EMERGENCY CONTACT

Name: ____ Phone: ______________________

Relation to Patient: ________________________________

REFERRAL SOURCES

How did you hear about us?

Family, friend, website, other (please specify) _______________________________________

ADDITIONAL INFORMATION ABOUT YOUR DENTAL HEALTH
(Check if applies to you)

Question		
Do you have a strong gag reflex?	○ yes	○ no
Do your gums bleed when you brush or floss?	○ yes	○ no
Are your teeth sensitive to hot and cold?	○ yes	○ no
Have you had recent surgery in your mouth?	○ yes	○ no
Are you grinding or clenching your teeth?	○ yes	○ no
Do you dislike the color of your teeth?	○ yes	○ no
Do you have spaces between your teeth that bothers you?	○ yes	○ no
Do you have chips or uneven edges on your teeth?	○ yes	○ no
Do you feel that your teeth are too long or too short?	○ yes	○ no
Are your teeth too crowded or crooked?	○ yes	○ no
Do you have existing crowns or dental work that you consider ugly?	○ yes	○ no
Are you self-conscious of your teeth and/or smile?	○ yes	○ no
Would you like to improve your existing smile?	○ yes	○ no