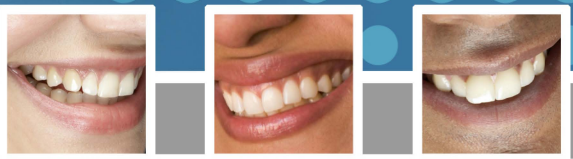
Northside Kenosha Dental
2600 22nd Ave.
Kenosha, WI 53140-4813

(262)658-1410



DENTAL HISTORY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Date of Last Xrays and Exam:

Date of last cleaning:

Have you had problems with prior dental treatment?

Are you experiencing discomfort now?

Have you been anxious about having dental treatment?

◯ Yes ◯ No

What concerns do you currently have with your oral health or smile?

- ☐ jaw joint pain
- ☐ clenching or grinding
- ☐ crowding/ crooked teeth
- ☐ spaces in between teeth
- ☐ missing teeth
- ☐ loose tooth/teeth
- ☐ unhappy with appearance of teeth
- ☐ tooth sensitivity to hot/cold or biting
- ☐ food gets caught in between teeth
- ☐ bad breath
- ☐ Other

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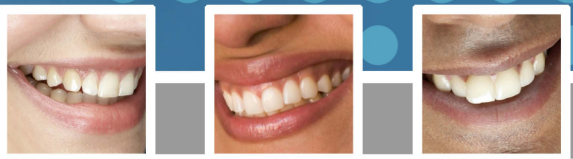

Have you ever had orthodontic treatment?

◯ Yes ◯ No

If yes, when?

Have you ever had periodontal treatment (scaling root planning, or periodontal surgery)?

◯ Yes ◯ No

If yes, when?

Are you interested in learning more about the following?

- ☐ teeth whitening
- ☐ Invisalign
- ☐ Veeners
- ☐ tooth colored fillings
- ☐ dental implants
- ☐ how to prevent periodontal disease
- ☐ tooth replacement options
- ☐ at home oral hygiene care

What is a cool/ interesting fact about you?

What can we do to make this your best dental experience yet?

Signature: _____ Date: _____

Response Date: _____