Welcome to

Implant Dentistry & Perio Rehab

with William Neale, DDS, MS

We want to learn as much as possible about your dental condition.
Please take a few minutes to complete this form.

1. How did you learn about Dr. Neale's office?

2. For You, What is the most important thing about today's visit?

_____

3. Why is that important to you ?

_____

4. Do you have a family dentist? YES NO

If so, who? _____

How long have you been going to him/ her?_____

5. Are you having any discomfort? YES NO Hot Cold Biting pressure

6. Can you locate the origin of the pain to one particular tooth or area?

Upper Right/ Upper Left Lower Right/ Lower Left

7. How long ago did you first notice the problem? _____

8. Do you have a sweet snack habit? YES NO

If yes, describe _____

9. Do you smoke or use smokeless tobacco? YES NO

10. Do you drink alcoholic beverages daily? YES NO

11. Does food pack between your teeth? YES NO

12. Do you have any loose teeth? YES NO

13. Do you grit/grind/clench your teeth? YES NO

Day time While sleeping Jaw muscles sore in the morning

14. Have you noticed?: Bleeding gums Foul taste Bad breath odor

15. On a scale of 1-10 how important is it to keep your natural teeth for a lifetime? 1 2 3 4 5 6 7 8 9 10

16. In 1-2 sentences, tell me what concerns you most about your mouth?

_____

17. Have you had any previous periodontal treatment?

(Surgery/Root Planning and Scaling?)

18. Are you happy with the appearance of your teeth/gum/smile? YES NO

19. Would you like to discuss enhancing the appearance of your smile? YES NO

20. What do you not like about your smile?_____

21. Would you like to discuss how to make your teeth WHITER? YES NO

22. How would you like your teeth to look in 5 years? _____

23. Most important thing about you Teeth?

_____

24. Please circle the area that reflects the condition of your teeth?

Poor<<<———— Average————————>>>>Excellent

Patient's Signature———————— Today's Date ————————