# WELCOME TO OUR OFFICE

**Thank you** for choosing us to help you with your dental care! Our pledge is to help you have a **healthy and happy smile, a *SMILE FOR LIFE***. In addition to providing advanced, comprehensive dentistry, we hope to develop a **lifelong relationship** with each of our patients. We pride ourselves in treating you as we would want to be treated by offering caring, **quality dental services.**

It is very important that we maintain **open communication** with you at all times. If at any time we can be of assistance to you regarding our services, dental information or finances, we urge you to **speak to our staff**. To help you best, please provide the following information.

Very Sincerely,
Ron M. Ask, DDS, Craig A. Kinzer, DDS, Dwight D. Simpson, DDS, Leon Roda III, DDS, Jerhet R. Ask, DDS

# DENTAL HISTORY

**Name**_____ **Date** _____

**How can we help you today?** _____
Former Dentist: _____ Phone: _____
Address: _____
Date of last x-rays and exam: _____ Date of last cleaning: _____

❑ NO ❑ YES Have you ever had orthodontic treatment? When? _____
❑ NO ❑ YES Have you ever had periodontal treatment, such as deep cleaning/root planning or surgery?
❑ NO ❑ YES Do you have to be pre-medicated with antibiotics before a cleaning or major dental work?
❑ NO ❑ YES Are you anxious about having dental treatment? Why? _____
**❑ NO ❑ YES Has fear prevented you from seeking dental treatment? Why? _____**
❑ NO ❑ YES Would you like a sedative to help you relax, i.e. Valium or Nitrous Oxide (laughing gas)?
❑ NO ❑ YES Are you fearful of losing your natural teeth in your lifetime?
❑ NO ❑ YES Have you ever had complications from dental treatment? What? _____
❑ NO ❑ YES Are your teeth sensitive/painful to hot/cold or anything else? Explain: _____
❑ NO ❑ YES Does food get caught between your teeth? Where? _____
❑ NO ❑ YES Do you have difficulty chewing on both sides of your mouth? Which side? _____
❑ NO ❑ YES Are you aware of clenching or grinding your teeth?
❑ NO ❑ YES Do you have bad breath problems?
❑ NO ❑ YES Have you bleached your teeth in the past? What method?_____

**What did you like the <u>most</u> about any dentist you have seen?** _____
**What did you like the <u>least</u> about any dentist you have seen?** _____
**Rate your smile from 1 to 10 (1=Worst 10=Best):** _____
**What would it take, in your opinion, to get your smile to a "10"?** _____
**Do you prefer to learn every detail of your dental care <u>OR</u> just an overall explanation?** _____
**Would you like to be presented with the best dentistry has to offer for your long-term health <u>OR</u> be presented with the basics to get you by for several years?** _____

## FAMILY INFORMATION

Parents (if patient is a child): _____ Spouse: _____

| | Name | Age | Name | Age | Name | Age |
|---|---|---|---|---|---|---|
| Children: | _____ | _____ | _____ | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ | _____ | _____ | _____ |

Emergency Contact/Nearest Relative NOT living with you: _____Relationship: _____
Complete Address: _____
City: _____ Zip: _____ Phone: _____