

Welcome...



We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we can provide the best care possible for you. Thank you!

Brian McKay, DDS & Team

Dental History ~

What prompted you to call our office for an appointment? _____

When was the last time you were seen by a dentist? _____

Previous dentist's name? _____

Did you have regular dental care as a child? Y N

As a child, did you have a lot, average, or very little tooth decay? _____

Do you have any dental anxieties? If so, what is the origin of your anxiety? _____

Has a dental office ever helped you set up a treatment plan? _____

As you come into a new dental practice, what are your expectations, concerns, and or/priorities? _____

Dentally, what would you like to achieve? What does the "finish line" look like? _____

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do? _____

Guided Tour Through Your Mouth ~

Have you had cosmetic dentistry (eg. Bonding, Veneers)? _____

Periodontal Screening ~

Have you ever had..... Pocket measurements? Y N Bone loss evaluation? Y N
 Have you ever been treated for periodontal disease? Y N Root Planing? Y N
 Do you suspect that you have mouth odor? Y N
 Have you noticed any loosening or mobility of your teeth? Y N
 Do you suffer from pain and/or swelling of your gums, or have any pus around your gums? Y N

Habits ~

Do you... Clench your teeth during the day? Y N Grind your teeth at night? Y N
 Bite your lips or cheeks regularly? Y N Sleep with your mouth open? Y N
 Chew tobacco or snuff? Y N Smoke cigarettes? Y N
 Hold foreign objects with your teeth (pencils, etc.)? Y N

Problems of the Jaw ~

Have you ever been treated for TMJ? Y N
 Have you ever experienced: Clicking of the joints? Y N Pain? Y N
 Difficulty chewing? Y N Locking? Y N
 Chronic neck or shoulder pain? Y N Chronic headaches? Y N
 Morning headache? Y N Migraine headache? Y N

Please share with us any additions thoughts, comments, or concerns regarding your dental experiences or expectations ~

Enriching Lives by Exceeding Expectations

Name _____

Date _____