PONZIO DENTAL

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DENTAL EVALUATION

Name: _____ Date:_____

Whom may we thank for referring you to our office? _____

Reason for today's visit? _____

When was your last dental visit? _____

Are you experiencing any pain? _____

Do you have any sensitivity to hot or cold?_____

Do you have any difficulty chewing?_____

Have you had previous orthodontic treatment?_____

Are you satisfied with the current appearance of your teeth?_____

If not, what would you change?_____

Do you have any pain in or around your ears or the muscles of your face?_____

Do you suffer from frequent headaches, neck or shoulder aches?_____

Do you have any missing teeth you would like replaced?_____

Have you had any dental surgery in the past?_____

Have you had any difficulty with previous dental work?_____

If yes, please explain:_____