DENTAL EVALUATION

PONZIO DENTAL

Name: _____

Date: _____

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

What is the reason for today's visit? _____

When was your last dental visit? _____

Were x-rays taken at your last dental visit? _____

If so, please provide the following so that we may request images:

Office Name: _____ Phone #: _____

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 like to 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: _____

Additional Comments or Concerns: _____

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