



Arthur R. Kremer, DDS

New Patient Dental History

Reason for today's visit? _____

Date of Last Exam? _____ How often do you floss? _____

Previous Dentist's Name: _____ Reason for leaving: _____

Current Dental Problems: _____

Have you ever had an upsetting dental experience? YES NO Describe: _____

Are you happy with the appearance of your teeth? YES NO Explain: _____

Which characteristic do you feel is **most** important to you in your dental treatment? (Choose 1 or 2)

Expense Pain/Comfort Esthetics Function General Health Prevention

Check all that apply to you:

- My gums bleed when flossing
- Routine bad breath
- Smoke or use tobacco products
- Dry Mouth
- Diabetes
- Red swollen gums
- Stress
- Osteoporosis
- Loose teeth
- Frequent build up on teeth
- I have had a "deeper cleaning" in the past

Check all that apply to you:

- I have broken a tooth in the past
- I have had a crown come off
- I have chipped porcelain in my mouth
- My teeth are wearing short in the front
- My teeth are sensitive to cold
- I wake up with tightness in my jaw
- I have been told I grind my teeth
- I get frequent headaches or neck aches
- I have difficulty opening or closing my mouth
- I have clicking or popping in my jaw

Check all that apply to you:

- I drink soda, energy drinks, Gatorade, or juice
- I eat sweets
- I have had fillings placed in the past three years
- I don't brush twice a day
- I drink coffee with sugar
- I snack frequently during the day

Are you experiencing any of the following:

- Cold Sensitivity
- Heat Sensitivity
- Sensitivity when biting
- Sensitivity to sweets
- Sores or growths in your mouth
- Bleeding gums