DR. STEPHEN LIPINSKI
PARTNERS IN YOUR ORAL HEALTH

# Dental Form

*To serve you properly we will need the following information. All information will be strictly confidential. Please print.*

1. Does dental treatment make you nervous? (please circle) No Slightly Moderately Extremely
2. How often do you use dental floss? _____
3. How often do you brush your teeth? _____
4. Describe in your own words your present dental condition _____

_____

5. If you were to change anything in your mouth, what would you change? _____

_____

6. Date of your last dental visit _____
7. Have you ever had local anaesthetic (freezing)? YES NO
8. Where there any complications? YES NO
   If yes, specify: _____
9. Have you ever had any teeth extracted? YES NO
10. Were there any complications afterwards? YES NO
11. Do you have any medical or dental implants? YES NO
12. Do your facial muscles feel sore or tired on occasion? YES NO
13. Do you have frequent headaches? YES NO

*Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' to each item.*

| **Mouth** | | |
|---|---|---|
| Bleeding, Soft Gums | YES | NO |
| Unpleasant Taste/Bad Breath | YES | NO |
| Burning Tongue/Lips | YES | NO |
| Frequent Blisters (Lips/Mouth) | YES | NO |
| Swelling / Lumps in Mouth | YES | NO |
| Ortho Treatment (Braces) | YES | NO |
| Clicking/Popping Jaw | YES | NO |

| **Teeth** | | |
|---|---|---|
| Teeth Sensitivity (hot & cold) | YES | NO |
| Facial Pain | YES | NO |
| Difficulty Chewing | YES | NO |
| Difficulty Swallowing | YES | NO |
| Does food pack or catch between your teeth? | YES | NO |
| Clenching | YES | NO |
| Grinding | YES | NO |
| Shifting in teeth | YES | NO |

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.*

Patient/Parent/Guardian Signature: _____ Date: _____

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