Kenneth L. Andow
DDS • PC

Cosmetic and family dentistry with a caring touch

Dental History

Name: _____ Date: _____

Reason for today's visit: _____

Date of last dental visit: _____ Purpose of that visit? _____

Date of last teeth cleaning: _____ Date of last full mouth x-rays: _____

Our goal is to make your experience in our office exactly how you want it to be. Please complete the following so we can make you as comfortable as possible.

What concerns you most about your mouth? _____

Rate, in order of value from 1 to 4 (with 1 being the most important), what is most important to you in your dental care:

_____ Preventive Care

_____ Only what is necessary at the time (Cost is important)

_____ Comprehensive, Quality Care

_____ Other _____

Mark "YES" or "NO" next to each item.

Do you have dental exams on a regular basis? Every _____ months	YES ○	NO ○
Do you think you have cavities in your mouth now?	YES ○	NO ○
Are any of your teeth sensitive to:		
cold? Where? _____	YES ○	NO ○
hot? Where? _____	YES ○	NO ○
sweets? Where? _____	YES ○	NO ○
biting or chewing? Where? _____	YES ○	NO ○
Are you concerned about:		
Replacing missing teeth?	YES ○	NO ○
Eliminating any disease present in your mouth?	YES ○	NO ○
Gum Disease?	YES ○	NO ○
Bad Breath?	YES ○	NO ○
The appearance of your smile?	YES ○	NO ○
Jaw Pain (TMJ)?	YES ○	NO ○
Are your teeth wearing down?	YES ○	NO ○
Is keeping your natural teeth important to you?	YES ○	NO ○

Rate your level of apprehension you have regarding dental treatment. (10 being the most apprehensive and 1 being the least)

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

When Dr. Andow reviews your treatment plan with you would you like to know (please mark one):

○ The big picture of what needs to be done ○ All the treatment details along the way

NOTES: