BLACK DIAMOND DENTISTRY

Patient Name:_____

Date of Birth:_____

Last Visit to Dentist:_____

Previous Dentist:_____

Do you have, or have you ever had any of the following:

(Circle all that Apply)

Bleeding, sore gums

Unpleasant taste or bad breath

Burning tongue or lips

Frequent blisters on lips, or in your mouth

Swelling or lumps in your mouth

Clicking or popping of your jaw

Difficulty opening or closing jaw

Loose teeth

Teeth Sensitive to Hot

Sensitive to Cold

Sensitive to sweets

Sensitive to biting

Food Impaction

Clenching or grinding

Shifting of teeth change of bite

Do you like your teeth?

Yes_____ No_____

Oral Hygiene, do you use any of the following?

Brush

Dental Floss

Fluoride Rinse

Other _____

My brush is:

soft medium hard

Electric

I would like additional information on:

Bleaching

Cosmetic dentistry

Implants

Naturopathic/Biological Dentistry

May we request x-rays?
Yes ____ No_____

Have you ever had complications following dental treatment?

Yes_____ No_____

Have you ever been admitted to a hospital, or needed emergency care in the last 2 Years?

Yes_____ No_____

Are you under care of a Physician?

Yes_____ No_____

Do you have any health problems that need further clarification?

Yes_____ No_____

Name of Physician

_____

Patient Signature: _____ Date: _____