



GETTING TO KNOW YOU
 Sean Wilson DDS
 Cosmetic, Restorative, and Implant Dentistry
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NAME: _____ DATE: _____

What name would you like us to call you? _____

Please describe the reason for your consultation today:

How long has this been going on and what other events apply to today's visit?

Why have you decided to deal with this now?

Have you consulted with any other dentist about this? Yes No If yes, what was discussed or done?

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you:

- | | | | |
|-------------------------------|--|-----------------------------------|--|
| Have gum disease (gingivitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grind your teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose or broken teeth or fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No | Food collection between teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Pain or tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores, blisters or growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain around ear | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Sensitivity to: cold heat sweets when biting or chewing

Would you like to know your options to: Improve your smile Look younger Keep your teeth

What are your priorities and what would you like to see done now?

