WHAT SPECIFICALLY IS PROMPTING YOU TO SEEK DENTAL TREATMENT? _____

_____

Does this problem occur? ❒ Constantly ❒ Daily ❒ Weekly ❒ Monthly

When are your symptoms worse? ❒ AM ❒ PM ❒ While eating ❒ Other _____

Have you had swelling with this problem? ❒ Currently ❒ Previously

How would you describe your pain? ❒ Dull, aching ❒ Sharp, stabbing ❒ Throbbing ❒ Pressure

❒ Cold or hot sensitive ❒ Food (sweet) sensitive ❒ Continuous ❒ Intermittent

On a scale of 1-10 (1 is little pain; 10 is severe pain), rate your level of pain _____

Are you happy with your smile? ❒ Yes ❒ No

Would you like to improve your smile or teeth in any way? ❒ Yes ❒ No

❒ Whiten ❒ Replace silver fillings ❒ Replace missing teeth ❒ Close spaces

❒ Other _____

Would you like to keep your teeth the rest of your life? ❒ Yes ❒ No

Do you consider replacement of missing teeth important to your long-term dental health? ❒ Yes ❒ No

Please answer each question by checking the box which applies to you.

	Very Much	Moderately	Somewhat	Not at all
1. How much anxiety do you feel when you are at the dentist?				
2. How much pain have you experienced in previous dental treatments?				
3. How much have you neglected your dental treatment?				
4. To what degree has your past experience of pain affected your acceptance of dental care?				
5. Have you ever cancelled or not appeared for a dental appointment				

Would you be interested in Sleep Dentistry Sedation? ❒ Yes ❒ No

Additional comments that will help us with your dental treatment: _____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can get access to this information.

I, the undersigned, have reviewed (or was offered) a copy of
Fitterling Dentistry's Notice of Privacy Policies.

Signature _____ Date _____

_____ I refuse to sign this acknowledgement.