North Hills Dental

Intake Questionnaire

I am a: New Patient Former Patient

Name: _____

Referred by: _____

Purpose of this appointment: Specific Concern General Oral Health

Specific concern: Broken Tooth Lost Filling Bleeding Gums Mobility

Area of concern: Upper Right Upper Left Lower Right Lower Left

Does the pain keep you awake at night? Yes No

Swelling? Yes No

Sensitivity? Hot Cold Sweets Biting

Are you taking pain medication? Yes _____ No

Have you been prescribed a pre-medication for dental visits? Yes No

Last dental visit: _____ **Where:** _____

Last cleaning: _____

Is there anything else the dentist should know? _____