

IMPLANTS • INVISALIGN • COSMETIC DENTISTRY • CEREC/3D

WELCOME TO DR. FRONING'S OFFICE. WE SINCERELY APPRECIATE YOU CHOOSING OUR OFFICE FOR YOUR DENTAL AND ORAL HEALTH CARE NEEDS. PLEASE BE ASSURED THAT WE WILL WORK HARD TO CONTINUALLY EARN THE TRUST THAT YOU HAVE PLACED IN US. IN ORDER FOR US TO SERVE YOU BETTER, PLEASE TAKE SOME TIME TO COMPLETE THIS INFORMATION FORM AS THOROUGHLY AS POSSIBLE.

DENTAL HISTORY

Last Name _____ First Name _____ Middle Initial _____
 Date of Birth _____
 Purpose of initial visit _____
 Are you aware of a problem? _____
 How long since your last dental visit? _____
 What was done at that time? _____
 Previous dentist's name _____
 Address _____ Tel _____
 When was the last time your teeth were cleaned? _____

Please answer the following questions.

YES NO N/A

YES NO N/A

Have you made regular visits? YES NO N/A
 Were dental x-rays taken recently? YES NO N/A
 Do you have a current pano or full mouth series? YES NO N/A
 Have you lost any teeth or have any teeth been removed? YES NO N/A
 Have they been replaced? YES NO N/A
 How have they been replaced?
 Fixed bridge Age _____
 Removable partial bridge Age _____
 Denture Age _____
 Implant Age _____
 Are you happy with the replacement? YES NO N/A
 Would you like to know about permanent replacements? YES NO N/A
 Have you ever had any problems or complications with previous dental treatment? YES NO N/A
 Do you clench or grind your teeth? YES NO N/A
 Does your jaw click or pop? YES NO N/A
 Have you experienced any pain or soreness in the muscles of your face or around your ear? YES NO N/A

Do you have frequent headaches, neckaches or shoulder aches? YES NO N/A
 Does food get caught in your teeth? YES NO N/A
 Are any of your teeth sensitive to
 Hot Cold Sweets Pressure?
 Do your gums bleed or hurt? YES NO N/A
 How often do you brush your teeth? 1x 2x's 3x's a day
 Do you use dental floss? YES NO N/A
 Are any of your teeth loose, tipped, shifted or chipped? YES NO N/A
 Are you unhappy with the appearance of your teeth? YES NO N/A
 How do you feel about your teeth in general? YES NO N/A
 Do you feel your breath is offensive at times? YES NO N/A
 Have you ever had gum treatment or surgery? YES NO N/A
 Have you had any orthodontic work? YES NO N/A
 Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? YES NO N/A
 Do you have any questions or concerns? YES NO N/A
 Explain _____

 Patient's (Guardian's) Signature

 Date

 Dentist's Signature

 Date

