

Hunter's Creek Dental

Dr. Khan

3932 Town Center Blvd.

Orlando, FL 32837

407-240-1500

Patient's Name: _____

Date: _____

What is the main reason for your visit today? _____

Are you currently having pain? Yes No Do you require antibiotics before dental treatment? Yes No

Is there anything about your smile that you don't like? _____

Do you like the appearance of your teeth? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing or biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you like to change anything about the appearance of your smile? Yes No

If so, what: _____

If we could enhance your smile by giving you whiter, more aligned teeth would you be interested? Yes No

Is there anything about your mouth that concerns you now? Yes No

If yes, explain: _____

How long has it been since you have seen a dentist and for what reason? _____

Were radiographs taken at this last visit? Yes No

Have you ever had orthodontic treatment? Yes No

Do you use dental floss, toothpicks? Yes No

Have you ever had wisdom teeth removed? Yes No

Do your gums ever bleed? Yes No

Are any of your teeth loose? Yes No

Do you have any swelling, sores or blisters in your mouth? Yes No

Have you ever been told that you have gum disease? Yes No

Have you ever visited a periodontist (Gum specialist)? Yes No

Do you smoke? Yes No

Do you feel you have unpleasant breath at times? Yes No

Are you interested in using sedatives while dental treatment is being performed? Yes No

What are your hobbies/interests/pastimes other than work? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant? _____
