NAME _____ _____ __ AGE ___ SEX: M □ F □ Patient #_____
Last First MI Social Security #

DENTAL HISTORY

Referring Dentist _____ _____ City _____
First Name Last Name

Briefly describe your problem: _____

How long have you had this problem? _____Day(s) _____Weeks(s) _____Months(s) _____ Years(s)

Check (X) all that apply:

PAIN: □ Never (If checked, go to SWELLING) **LOCATION:** □Upper Left □ Upper Right □ Upper Front
□ In the Past □ Today □ Lower Left □ Lower Right □ Lower Front

DURATION: □ Seconds □ Minutes □ Hours □ Constant **QUALITY:** □ Dull pain □ Throbbing pain □ Sharp Pain

PAIN SCALE (check (X) 0-10):

Mild *Severe*

0	1	2	3	4	5	6	7	8	9	10
____	____	____	____	____	____	____	____	____	____	____

PROVOKED BY: □ Cold □ Hot □ Biting □ Sweet □ Spontaneous (unprovoked) □ Other _____

SWELLING: □ None □ In the Past □ Today **Today's Anxiety Level:** (0-10)_____

Do you use Nitrous Oxide (Laughing Gas)? □ Yes □ No (60.00 fee)