KERNAGIS DENTAL EXCELLENCE

DENTAL EXCELLENCE at FISH HAWK

South Shore Dental Excellence

RICHARD KERNAGIS, DMD ◆ JENNIFER WYNN KERNAGIS, DMD

DENTAL HISTORY

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit: _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous Dentist's name: _____
   Address: _____ Phone: _____
6. When was the last time your teeth were cleaned? _____
7. Have you made regular visits?..... ☐ Y ☐ N
8. Were dental x-rays taken?..... ☐ Y ☐ N
9. Have you lost any or have any teeth been removed?..... ☐ Y ☐ N
10. Have any been replaced?..... ☐ Y ☐ N
11. How have they been replaced?
    ☐ Fixed Bridge ☐ Removable Bridge ☐ Denture ☐ Implant
12. Are you unhappy with the replacement?..... ☐ Y ☐ N
13. Would you like to know about permanent replacements?..... ☐ Y ☐ N
14. Have you ever had any problems or complications with previous dental treatment? Please explain. _____ ☐ Y ☐ N
15. Do you clench or grind your teeth?..... ☐ Y ☐ N
16. Does your jaw click or pop?..... ☐ Y ☐ N
17. Have you experienced and pain or soreness in the muscles in your face around your ear?..... ☐ Y ☐ N
18. Do you have frequent headaches, neckaches or shoulder aches?.. ☐ Y ☐ N
19. Does food get caught in your teeth?..... ☐ Y ☐ N
20. Are any of your teeth sensitive to? ☐ hot ☐ cold ☐ sweets ☐ pressure
21. Do your gums bleed or hurt?..... ☐ Y ☐ N
    When? _____
22. Do you experience dry mouth?..... ☐ Y ☐ N
23. How often do you brush your teeth? _____
24. How often do you use dental floss? _____
25. Are any of your teeth loose, tipped, shifted or chipped?..... ☐ Y ☐ N
26. Are you unhappy with the appearance of your teeth?..... ☐ Y ☐ N
27. How do you feel about your teeth in general?
28. Do you feel your breath is offensive at times?..... ☐ Y ☐ N
29. Have you ever had gum treatment or surgery? What? _____
    Where? _____ When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____

COMMENTS

I certify the above information is complete and accurate

Patient/Guardian's Signature _____ **Date** _____

Dentist's Signature _____ **Date** _____

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ABOUT YOUR SMILE

1. I love the way my smile looks: ☐ True ☐ Somewhat True ☐ Not True

2. I feel comfortable showing my teeth when I laugh or smile: ☐ True ☐ Somewhat True ☐ Not True

3. If I could change anything about my smile it would be (check all that apply):

- ☐ Color of my teeth
- ☐ Size of my teeth
- ☐ Shape of my teeth
- ☐ Too much or too little of teeth show when I smile
- ☐ Too much or too little of gums show when I smile
- ☐ Other: _____
- ☐ Gaps between my teeth
- ☐ Alignment of my teeth

4. I have (check all that apply):

- ☐ Sensitive or receding gums
- ☐ Missing teeth
- ☐ Broken / chipped teeth
- ☐ Old or discolored fillings
- ☐ Old crowns that have dark edges
- ☐ Other: _____

5. In my line of work or lifestyle of often (check all that apply):

- ☐ Visit businesses or clients
- ☐ Speak publicly
- ☐ Travel
- ☐ Minimal interaction with others
- ☐ Other: _____

6. If I had a smile make-over I would feel (check all that apply):

- ☐ More confident
- ☐ Just OK
- ☐ More optimistic
- ☐ No different
- ☐ Healthier
- ☐ Other: _____

7. I would like to know about how dentistry can help with one or more of these issues regarding myself or someone in my family:

- ☐ Chronic bad breath
- ☐ Sports mouthguards
- ☐ Grinding teeth
- ☐ Snoring
- ☐ Other: _____

8. I prefer appointments in the (check all that apply):

- ☐ Early morning
- ☐ Late morning
- ☐ Early afternoon
- ☐ Late afternoon
- ☐ No preference
- ☐ Other: _____

9. The most important features I want in a dental office are (check all that apply):

- ☐ Convenient location
- ☐ Preventative care
- ☐ Comfortable atmosphere
- ☐ Long-lasting results
- ☐ Convenient appointment times
- ☐ Treatment choices
- ☐ Caring and attentive staff
- ☐ Low to no-pain dentistry
- ☐ Short appointments
- ☐ State-of-the-art technology
- ☐ Minimal change in appearance during treatment
- ☐ Other: _____

10. Is there anything else that you want our office to know about you that will help us to serve you better?

_____

_____

_____