Tsar Dental Excellence
Cosmetic
Restorative
Neuromuscular Dentistry

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Located in the Amtrust Bank building • 603 Village Boulevard, Suite 304 • West Palm Beach, Florida 33409

Dental History

First Name: _____ Last Name:_____ Birthdate:_____

1. Are Your Teeth Sensitive To:
   - Heat YES NO
   - Sweets YES NO
   - Cold YES NO
   - Biting pressure YES NO

2. Does Food Constantly Get Stuck Between Certain Teeth In Your Mouth? YES NO

3. Do You Get Frustrated Because You Always Have Something To Be Treated Or Repaired When You Visit A Dentist? YES NO

4. Are You Dissatisfied With Your Teeth In Any Way? YES NO
   Color Shape spaces other

5. If Any Of Your Mercury Amalgam Silver Fillings Need Replacement, Would You Prefer To Have More Natural Tooth-Colored Restorations Instead? YES NO

6. Do Your Gums Bleed When Brushing? YES NO

7. Do You Ever Avoid Any Part Of The Mouth While Brushing? YES NO

8. Do You Have An Unpleasant Taste Or Odor In Your Mouth? YES NO

9. Do You Smoke Or chew tobacco? YES NO

10. DO You Frequently Snack Between Meals On Sweets, Or Chew Gum? YES NO

11. How Often Do You Brush Your Teeth?
Brush_____ floss _____

12. When Was Your Last Dental Appointment?
_____

13. What Did You Have Done?
_____

14. What Prompted You To Seek Dental Care At This Time?
_____

15. Do You Want To Learn How To Control Dental Disease And Retain Your Health? YES NO

16. Has The Fear Of Discomfort Kept You From Regular Dental Visits? YES NO

17. Are You Deeply Concerned About The Finances Required To Return Your Mouth To Excellent Dental Health? YES NO

We have several comfort items available to you to increase your comfort while you are in the office. Please check all that you would like.

- Knee support pillow
- Neck pillow
- Massage chair
- Blanket
- Tea/Coffee
- Nucalm - Anti Anxiety, drug free, Sedation System
- Nitrous Oxide (Laughing gas)
- iPod With noise canceling headset

TMJ/TMD SCREENING

Have You Experienced Or are you currently experiencing:

- Clicking Or Popping Of The Jaw? YES NO
- Difficulty Opening / Closing Mouth? YES NO
- Pain In Your:
  - Jaw Joint YES NO
  - Ear YES NO
  - Side Of Face YES NO
- Do You Clench Or Grind Your Teeth? YES NO
- Do You Get Frequent Headaches? YES NO
- Do You Smoke? YES NO
- Do You Have Sleep Apnea? YES NO

Patient Signature: _____ Date: _____