



GETTING TO KNOW YOU
 Christian W. Hahn, DDS, AAACD
 Exquisite Family & Advanced Cosmetic Dentistry
 502.228.4585 - IdealDentistry.com

NAME: _____

Date: _____

What would you like to be called? _____

Please describe the reason for your consultation today: _____

How long has this been going on and what other event's apply to today's visit: _____

Why have you decided to deal with this now: _____

Have you consulted with any other dentist about this: Yes No If yes, what was discussed or done:

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you have: (Check those that apply)

- | | | |
|---|--|---|
| Gum Disease <input type="checkbox"/> | Lip or cheek biting <input type="checkbox"/> | Grind your teeth <input type="checkbox"/> |
| Loose or broken teeth/fillings <input type="checkbox"/> | Clicking or popping jaw <input type="checkbox"/> | Bad breath <input type="checkbox"/> |
| Food collection between teeth <input type="checkbox"/> | Jaw pain or tiredness <input type="checkbox"/> | Pain around ear <input type="checkbox"/> |
| Sores, blisters or growths <input type="checkbox"/> | Dry mouth <input type="checkbox"/> | |

Sensitivity to: cold hot sweets when biting or chewing

How Happy Are You With Your Smile? Please Circle (10 Highest ~ 1 Lowest) 1 2 3 4 5 6 7 8 9 10

What 3 things would you change if you could? #1 _____

#2 _____

#3 _____