JUDSON VALSTAD, DMD
PAMELA VALSTAD, DMD

Name:_____ **DENTAL HISTORY** Date:_____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? Yes / No
Reason_____

| | | |
|---|---|---|
| Are you currently in pain? Yes / No | Have you ever had gum or Periodontal Treatment? Yes / No | Do your gums bleed? Yes / No |
| Do you now or have you had any pain/ discomfort in your jaw joint (TMJ)? Yes / No | Do you feel like you clench or grind? Yes / No | |
| Are you happy with the color of your teeth? Yes / No | How many time do you: Floss / week? Brush / Day? | When was your last dental cleaning? |
| Are your teeth sensitive to hot, cold or anything else? Yes / No | Have you ever had a serious difficult problem with any previous dental work? Yes / No | |
| How would you rate your level of dental anxiety? None High 0 2 4 6 8 10 If so, do you prefer nitrous? Yes / No | When was your last dental visit? | How can we accommodate you during your dental visit? |

Valstad Dental offers a wide variety of services to enhance and keep your smile beautiful.
Please circle any services below you would like our staff to discuss with you during your visit.

Extractions Teeth Whitening Night / Sport Guards

Implants Crown / Bridge Partials / Dentures

Do you feel tired throuhgout the day? Yes/No Have you ever been told you occasionally snore? Yes/No
Do you wish you had slept better and had more energy? Yes/No
Have you or a loved one been prescribed a CPAP? Yes/No

Emergency Contact information:

Name: Relationship:

Address: Phone:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responibility to inform this office of any changes in my medical status.

Patient's Signature: Date:

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