

## GETTING TO KNOW YOU

*Dr. Dianna Lenick*

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Phone: 304-342-6918 Fax: 304-344-9302

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What name would you like us to call you? \_\_\_\_\_

Please describe the reason for your consultation today:

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How long has this been going on and what other events apply to today's visit?

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Why have you decided to deal with this now?

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Have you consulted with any other dentist about this?  Yes  No

If yes, what was discussed or done?

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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 gum disease (gingivitis)  Yes  No Lip or cheek biting  Yes  No

Grind your teeth  Yes  No Loose or broken teeth or fillings  Yes  No

Clicking or popping jaw  Yes  No Food collection between teeth  Yes  No

Jaw pain or tiredness  Yes  No Sores, blisters or growths  Yes  No

Pain around ear  Yes  No Bad breath  Yes  No

Sensitivity to:  cold  heat  sweets  when biting or chewing

Would you like to know your options to:  Improve your smile  Look younger  Keep your teeth

What are your priorities and what would you like to see done now?

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