Robert Lipkowitz
GENERAL • COSMETIC • IMPLANT
DENTISTRY

_____

Last **First** **Middle**

Accurate answers to the following questions will allow Dr. Lipkowitz to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ☐ **Yes** ☐ **No**
2. Have you ever had serious trouble associated with previous dentistry? ☐ **Yes** ☐ **No**
3. Does dental treatment ever make you nervous? ☐ **No** ☐ **Slightly** ☐ **Moderately** ☐ **Extremely**
4. Date of last dental visit: _____
5. Have you ever been treated for periodontal disease? ☐ **Yes** ☐ **No**
6. How often do you brush? _____
7. Toothbrush bristles are: ☐ **Soft** ☐ **Medium** ☐ **Hard**
8. Do you have frequent headaches or migraines? ☐ **Yes** ☐ **No**

Do you have or have you ever had any of the following?

MOUTH	YES	NO	TEETH	YES	NO
Bleeding/Sore Gums	☐	☐	Loose teeth	☐	☐
Unpleasant/Bad Taste	☐	☐	Sensitive to hot	☐	☐
Burning tongue/Lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters on Mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/Lumps in Mouth	☐	☐	Sensitive to biting	☐	☐
Ortho Treatment (Braces)	☐	☐	Food impaction	☐	☐
Biting Cheeks/Lips	☐	☐	Shifting in bite	☐	☐
Clicking/Popping Jaw	☐	☐	Change in bite	☐	☐
Difficulty Opening/Closing Jaw	☐	☐	Clenching/grinding	☐	☐

Do you use any of the following?

	YES	NO
Standard toothbrush	☐	☐
Electric toothbrush	☐	☐
Fluoride rinse	☐	☐
Dental floss	☐	☐
Tooth whitening products	☐	☐

Other _____

These are the things that are important to me about my dental health:

_____

What do you fear most about dental care?

_____