Alexis A. Atchinson, DDS, PC

"Creating Healthy Smiles"

Dental History:

Thank you for choosing our practice for your dental care. In order for us to serve your oral health needs, please let us know the following about yourself:

Patient Name:___________________ Date:____________________

- **Have you ever been told you have gum disease?: Y/N**

  If so can you call your last Periodontal Maintenance?:______________________________

  What about your last "deep cleaning"?:____

- **Is there anything about your smile or teeth that you could change?:**

  Whiter______ Straighter______ Longer______ Would you consider Orthodontics?: Y/N

- **Do you have any of the following risk factors for sleep apnea?:**

  Snoring______ Grinding Teeth______ Gastric Reflux______

- **Do you have any of the listed risk factors for oral cancer?:**

  Alcohol use ______ Tobacco______ Vaping ______ HPV______

- **Do you consider yourself at a High Risk for Cavities?: Y/N**

  Are you interested in knowing how to stop the "cavity disease?" : Y/N

- **Please rate your anxiety regarding dental care:**

  None______ Mild______ Moderate______ Extreme______

Which days and hours are more convenient for your dental appointments? (Circle)

Monday Tuesday Wednesday Thursday Friday Saturday

Morning (7-12PM) Afternoon (2-5PM) Evening (5-7PM)

Assistant/Dr. Notes: