FAMILY DENTISTS
KARL BREUCKMANN, DDS
www.OlatheFamilyDentists.com
OLATHE 913-782-6533

We are happy to have you join our great family of patients. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you. Thank you!

Name _____ Birthdate _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ City, State_____

How often do you have dental examinations? _____

How often do you brush your teeth? _____How often do you floss? _____

What other dental aids do you use? (waterpik, electric toothbrush, etc.) _____

Do you have any dental concerns? □ Yes □ No

If yes, please describe: _____

DO YOU HAVE CONSISTENT PROBLEMS WITH:

Sensitive teeth? □ Yes □ No
If yes, sensitivity to:
□ Hot □ Cold □ Pressure □ Sweets
Dry mouth or excessive thirst? □ Yes □ No
Difficulty chewing? □ Yes □ No
Popping/clicking in your jaw? □ Yes □ No
Jaw pain? □ Yes □ No
Headaches? □ Yes □ No
Difficulty in opening/closing the mouth? □ Yes □ No
Tired jaws, especially in the morning? □ Yes □ No
Unpleasant odor or taste in your mouth? □ Yes □ No
Swelling/lumps/sores in your mouth or jaw? □ Yes □ No
Bleeding Gums? □ Yes □ No
Food catching between teeth? □ Yes □ No
Loose teeth or change in your bite? □ Yes □ No
Discolored teeth? □ Yes □ No
Broken Teeth or Fillings? □ Yes □ No

HAVE YOU EVER HAD:

Orthodontic treatment (braces)? □ Yes □ No
Oral surgery (tooth extractions)? □ Yes □ No
Periodontal (gum) treatment? □ Yes □ No
A bite plate or mouth guard? □ Yes □ No
A serious injury to the mouth or head? □ Yes □ No
Treatment for TMJ (jaw joint) disorders? □ Yes □ No
Anorexia and/or Bulimia? □ Yes □ No
Frequent Heartburn/GERD? □ Yes □ No

DO YOU:

Clench or grind your teeth? □ Yes □ No
Bite your lips or cheeks regularly? □ Yes □ No
Bite your fingernails? □ Yes □ No
Hold foreign objects with your teeth? (pens, nails, etc.)
□ Yes □ No
Mouth breathe while awake or asleep? □ Yes □ No
Snore or have any other sleeping disorders? □ Yes □ No
Regularly chew/suck on hard candy or mints? □ Yes □ No
Drink soft drinks or energy drinks? □ Yes □ No
Smoke/chew tobacco or use other tobacco products?
□ Yes □ No
If yes, please describe the type, amount, and number of years using tobacco:
_____
_____

Are you nervous or fearful of dental treatment?
□ Yes □ No
Are you dissatisfied with the way your teeth look?
□ Yes □ No
How would you rate your smile?
Worst 1 2 3 4 5 6 7 8 9 10 Best

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe:
_____
_____
_____

I would like to learn more about: □ Invisalign □ Whitening □ Cosmetic Dentistry □ Implants
□ CEREC (one visit) Crowns □ Snoring/Sleep Apnea Appliance