



JUDSON VALSTAD, DMD  
 PAMELA VALSTAD, DMD

Name: _____		<b>DENTAL HISTORY</b>		Date: _____	
Your current dental health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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			When was your last dental visit?		How can we accommodate you during your dental visit?
If so, do you prefer nitrous? Yes / No					
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 throughout 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 responsibility to inform this office of any changes in my medical status.					
Patient's Signature: _____				Date: _____	