**ZWEIG FAMILY DENTISTRY**
*Your Family's Path to Dental Health*

Our office is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability . . . thank you!

What is the main purpose of your first visit and what would you like to get accomplished? _____

_____

_____

Briefly mention any positive or negative aspects of your previous dental visits _____

_____

_____

What do you already know about our office and what are your expectations? _____

_____

_____

## TREATMENT RECOMMENDATIONS OR TREATMENT OPTIONS?

*Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.*

*The following questions help us determine what is important to you, please rate on the following scale from 10 to 1.*

**1. How (dental) healthy would you like to be?**

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|

*10 (healthiest)* *1 (not a concern at this time)*

**2. Almost all dental problems are predictable and preventable. In order to not overwhelm you with excess details, how preventative (or proactive) would you like to be regarding dental disease?**

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|

*10 ("nip in the bud early")* *1 (wait until it hurts)*

**3. How important are dental cosmetics to you?**

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|

*10 (very important)* *1 (not important)*

*Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.*

**4. How important is facial cosmetics to you?**

| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|---|---|

*10 (healthiest)* *1 (not a concern at this time)*

**5. Anything else you would like to mention ?**_____

_____

_____

Dr. Cristina Markiewicz Cosmetic and Family Dentist ▪ 400 S Reino Rd # 100 Newbury Park, CA 91320 ▪ ph: (805) 498-0400 e: zweigfamilydentistry.com

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## DENTAL HISTORY

*please indicate an answer for each general question*

How often do you brush? _____ How often do you floss? _____

Toothpoaste you use: _____ Mouthwash you use: _____

Other oral health care aids you currently use (waterpik, electric toothbrush, tongue scraper, etc.)

_____

Date of last Dental Exam: _____ Date of last clening: _____

Do you currently have any dental pain? ☐ YES ☐ NO if yes, where: _____

if yes to above, is this pain: ☐ Sporadic ☐ Constant ☐ Dull ☐ Sharp

Do you have any other current dental concerns / Comments ? _____

*Do you now, or have you ever (please circle)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Grind Teeth: | PRESENT | PAST | NEVER | Bite Nails: | PRESENT | PAST | NEVER |
| Bite Cheek: | PRESENT | PAST | NEVER | Smokeless Tobacco: | PRESENT | PAST | NEVER |
| Tongue Thrust | PRESENT | PAST | NEVER | Thumb / Finger: | PRESENT | PAST | NEVER |
| Mouth Breather: | PRESENT | PAST | NEVER | Toothpick / Stimulator: | PRESENT | PAST | NEVER |
| Bulimia/ Anorexia: | PRESENT | PAST | NEVER | Chewing Gum: | PRESENT | PAST | NEVER |
| Cigar / Cigarette: | PRESENT | PAST | NEVER | Candy: | PRESENT | PAST | NEVER |
| Pipe: | PRESENT | PAST | NEVER | Soft Drinks: | PRESENT | PAST | NEVER |

*Are your teeth senitive to: (please circle)*

| | | | |
|---|---|---|---|
| Hot or Cold: | PRESENT | PAST | NEVER |
| Biting / Chewing: | PRESENT | PAST | NEVER |
| Sweets: | PRESENT | PAST | NEVER |

*Have you ever had: (please circle)*

| | | | |
|---|---|---|---|
| Orthodontic Treatment: | PRESENT | PAST | NEVER |
| A bite plate of guard: | PRESENT | PAST | NEVER |
| Periodontic Treatment: | PRESENT | PAST | NEVER |
| Oral Surgery: | PRESENT | PAST | NEVER |
| Serious injury to mouth or head | PRESENT | PAST | NEVER |

Is there anything about your teeth or smile that you dont like or would like to change?_____

_____

_____

_____

Is there anything else about your teeth or dental history that you want us to know?_____

_____

_____

_____

**CONSENT FOR MYSELF OR MINOR PATIENT:**
The undersigned hereby authorizes Dr. Markiewicz and employees to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Markiewicz to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Markiewicz to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with above referenced patient and further authorize and consent that Dr. Markiewicz choose and employ such assistance she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

**SIGNATURE OF PATIENT, PARENT OR GUARDINAN** _____ **DATE:** _____ **WITNESS:** _____