



Center for
Restorative
Dentistry

Stephen T. Swallow, DDS

ACQUAINTANCE FORM

Date _____

Patients Name _____ Single/Married _____

Whom may we thank for this referral? _____

What Prompted you to seek dental services at this time? _____

How long has it been since your last dental examination? _____

How often do you have your teeth examined? _____ Xrays? _____

When were your teeth last **cleaned**? _____ Xrays of all Teeth? _____

What treatment was rendered after your last appointment? _____

Has **FEAR** or discomfort kept you from regular dental visits? _____

Are you satisfied with your past dentistry? _____

Are you satisfied with the **APPEARANCE** of your teeth? _____

How often do you brush your teeth? _____ **Floss?** _____

Have you ever received a thorough plan to preserve your teeth? _____

Are you concerned with bad breath? _____ Stained teeth? _____

Do you constantly have a bad taste in your mouth? _____

Do your gums bleed easily, feel tender or irritated? _____

Are any teeth sensitive to **HOT, COLD, SWEETS**? _____

Do you frequently snack between meals? _____ On sweets? _____ Starches? _____

Are you self-conscious about the appearance of you teeth? _____