

Getting To Know You

Center For Advanced Dentistry
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NAME _____ DATE _____

What name would you like us to call you? _____

Please describe the reason for your consultation today: _____

How long has this been going on and what other events apply to today's visit? _____

Why have you decided to deal with this now? _____

Have you consulted any other dentist about this? yes no If yes, what was discussed or done? _____

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or have any dentist or hygienist ever said that you:

Have gum disease (gingivitis) yes no Lip or cheek biting yes no

Grind your teeth yes no Loose or broken teeth or fillings yes no

Clicking or popping jaw yes no Food collection between teeth yes no

Jaw pain or tiredness yes no Sores, blisters or growths yes no

Pain around ear yes no Bad breath yes no

Sensitivity to: cold heat sweets when biting or chewing

Would you like to know your options to: Improve your smile Look younger Keep your teeth

What are your priorities and what would you like to see done now? _____

