

Dr. George D. Mason, D.D.S., P.C.

1213 N. Main • LaFayette, GA 30728

(706)-638-1114

New Patient Dental History

Previous Dentist & Phone# _____

Do We Have Permission To Contact Your Prev. Dental Office? Yes No

Est. Date Of Last Dental Visit _____

Reason For Changing? _____

Who Referred You To Us? _____

The Most Important Concerns Regarding My Dental Treatment Are: _____

How Often Do You Brush & Floss? _____

Oral Health Condition?

Excellent Good Fair Poor

Please Check All That Apply (If Yes Please Explain)

- | | |
|--|--|
| <input type="checkbox"/> Currently Having Dental Discomfort | <input type="checkbox"/> Prev. Unhappy/Unpleasant Dental Experiences |
| <input type="checkbox"/> Injuries To Mouth/Teeth/Head | <input type="checkbox"/> Missing Teeth (Other Than Ortho extractions & Wisdom Teeth) |
| <input type="checkbox"/> Have Missing Teeth been Replaced | <input type="checkbox"/> Ortho Appliances Now Or In Past |
| <input type="checkbox"/> Any Appearance Concerns (Color, Size, Crowding) | <input type="checkbox"/> Concerns About Gum Disease |
| <input type="checkbox"/> Gums Bleed When Brushing or Flossing | <input type="checkbox"/> Does it Hurt to Bite or Chew |
| <input type="checkbox"/> Do You Clench or Grind Your Teeth | <input type="checkbox"/> Do You Want Your Mouth Properly Restored |
| <input type="checkbox"/> Does Dental Treatment Make You Nervous | |

Child/Minor Patients Please Check All That Apply

- Any Mouth Habits (Thumb Sucking, Nail Biting, Nursing/Bottle, Pacifier, etc.)?
 Any Unusual Speech Habits ?
 Any Lost Teeth?
 Does Patient Recieve Assistance when Brushing & Flossing?

Signature _____ Date _____

Response Date: ____/____/____

Dr. George D. Mason, D.D.S.
Dr. Luke Thompson, D.M.D.
Dr. Michelle Ireland, D.M.D.
Dr. Lucelia Lima, D.D.S.

1213 North Main Street
LaFayette, Georgia
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masondentalarts.com

Please call within 24 hours to reschedule.