Emergency/Problem Focused Dental Appointment Information

Name: ______________________________________DOB:______________

Problem:____

Location

UR	UL	LR	LL

Swelling YES NO

ORAL	FACIAL	NECK

How long has the swelling been going on ________________________________

Pain YES NO

Intermittent	Spontaneous	Constant	Sharp	Dull	Throbbing	Localized	Generalized
☐	☐	☐	☐	☐	☐	☐	☐

How long has the pain been going on _____________________________________

Increased By

Cold	Hot	Pressure	Chewing	Sweet/Sugar	Waking you at night
☐	☐	☐	☐	☐	☐

How long has this been going on _______________________________________

When was your last cleaning? ____________________________

When was your last full exam? ____________________________

Dental office?____