Toothache Questionnaire

Patient's Name :		Date :	
Area of Pain : Upper Right Upper Left	Lower Left	Lower Right	
Duration of Pain : Days Weeks	Months	Years	
Type of Pain : Sharp Dull/Ache	Throb	Sensitive to Ho	ot/Cold
Does the pain wake you up at night or prevent you from	sleeping?	Yes	No
Does it hurt when you bite down on it?	Yes	No	
Does your pain linger? Yes	No		
How long will it linger? Mins.	Hours	Days	Months
Are you interested in learning about what it takes to save	e your tooth?	Yes	No
Would you like information for financial options if your	estimate exceeds y	our expectations?	Yes No
If we can get you comfortable, would you like a cleaning	today if schedule a	allows?	Yes No
Additional Comments :			
OFFICE USE ONLY	Paul F	I. Cloninger, d	.D.S., P.A.
Suspected Tooth #	-		
Perc:		1	
Palp:		A	
Dx:			
Tx Today:			