About Your Emergency

Name _____ Date _____

Age _____ New Patient? _____ Referred by _____

Please check all that apply:

1. Nature of emergency:
   - ❒ Broken tooth or filling
   - ❒ Tooth loose
   - ❒ Lost or broken crown
   - ❒ Gum bleeding
   - ❒ Sore in mouth
   - ❒ Difficulty opening, jaw pain

2. Where?
   - ❒ Upper ❒ Lower
   - ❒ Right ❒ Left
   - ❒ Front ❒ Midway ❒ Back
   - ❒ Cannot tell
   - ❒ Other

3. Did you have an accident or injury? Please describe _____

4. Did you have recent dental work in the area? What _____ When _____

5. About how long has area hurt? _____ Any swelling? _____ Where? _____
   Has pain or swelling worsened ?_____ How suddenly? _____

6. Please check the closest description of your discomfort
   - ❒ Constant ❒ On and off ❒ Occasional
   - ❒ Lasts under 7-10 seconds each time ❒ Lingers more than 10 seconds
   - ❒ Dull ache ❒ Throbbing ❒ Sharp ❒ Quick "electric" shock
   - ❒ Radiates to whole side ❒ Ear hurts Other_____

7. Rate pain severity 1-10. (10 is worst)
   ___ Keep you up at night? ___ Wake you up? Other _____
   ___ Prevent work? ___ Prevent social activities?
   Anything relieve the pain? _____

8. Do any of the following make discomfort worse?
   - ❒ Hot coffee or soup ❒ Sweets ❒ Other _____
   - ❒ Cold drink ❒ Pressing on gum in area.
   - ❒ Biting ❒ Bending over or lying down.

9. Anything else we should know about? _____

10. Medical update: ❒ Change in medications? ❒ Hospitalized?
    Other? _____

11. Insurance, employment or address change? _____
    _____

Patient Signature _____

(Please use reverse side if more space is needed.)