Idaho Oral & Maxillofacial Surgery, PC
Timothy T. Hopkins, DDS, MS

Idaho Smiles Patient Evaluation

Name:_____ Birth Date:_____

Idaho Smiles ID #: _____

Please circle the option that best describes your situation.

Do you have pain? None occasional continuous
If yes, what tooth # or area is your pain associated with?
_____

Do you have swelling? Y N
If yes, what tooth # or area is your swelling associated with?
_____

Is your mouth limited to opening? Y N

Have you been hospitalized recently for dental pain? Y N
Date hospitalized: _____

Have you been treated for any of the above symptoms by your referring dentist? Y N

If yes, were you treated with antibiotics or given any pain medication for symptoms related to dental pain? Y N
Date: _____ Description: _____

List any other concerns associated with your reason for visiting our office:_____
_____

_____ _____
Signature **Date**