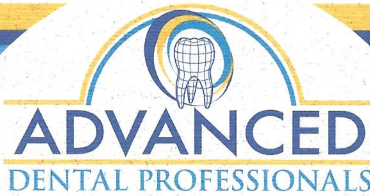

Dr. Neal C. Johnson | Dr. Spencer E. Zaugg

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DENTAL EMERGENCY CALL

Date: ________________ Referred By: ____________________________ Appt. Date ____________________

Name: ____ DOB: _________________________________

Address: ____

Telephone: Home: ____________________ Cell: ______________________ Work: _______________________

How long since your last dental visit? ________________ Name of previous dentist ___________________

What was done at last visit? _______________________________________ Any X-rays? _________________

Which tooth is bothering you?

______ Upper ______ Left ______Front ______ Can't tell

______ Lower ______Right ______Back

Describe the pain

______ Extreme ______ Throbbing ______ Dull Ache ______ Mild

______Constant ______ Comes and goes ______Getting Worse

Is there any swelling around the tooth? ____ Yes ____ No

Does the tooth feel loose? ____ Yes ____ No

Is it sensitive to: ____ Hot ____ Cold ____ Both ____Biting Pressure ____ Sweets

Is there a filling in the tooth? ____ Yes ____ No

____Recent ____ Old _____ Broken ____Lost

How long has it been hurting? ____

Do you take medication for the pain? ____

Does it relieve the pain? _______________________ Has the pain kept you awake at night? ____________

MEDICAL ALERTS: Heart murmur? _____ Artificial joints? _____ Rheumatic fever? ____

Heart surgery? ____ MVP? _____ Allergies to meds? _____

Comments: ____

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