

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

What was done at your last dental visit? _____

Previous Dentist's name _____

Address/Phone _____

How often do you visit the dentist? ___ every 4 months ___ every 6 months ___ every year ___ only when I have a problem

How often do you brush your teeth? _____ What kind of toothbrush do you use? ___ soft ___ medium ___ hard

How often do you floss? ___ rarely ___ only to remove debris ___ times per week ___ 5+ times per week

Are you apprehensive about having dental treatment done? ___ yes ___ no If yes, what bothers you most? _____

What, if anything has happened in previous experiences at the dentist that was reason not to return? _____

What methods have been used in the past to assure your comfort while having dental care?

___ Local Anesthetic ___ Nitrous Oxide ___ Pre-op Sedative ___ I.V. Sedation ___ Headphones

Please ✓ any statements which apply to you. If you have discomfort, please tell us where the problem is.

1. I have pain in my teeth when I:

a. ___ eat sweets or cold food/drinks

b. ___ have hot food/drinks

c. ___ chew on firm or hard foods

2. ___ Food catches between my teeth

3. ___ Rough fillings catch floss or food

4. ___ My gums are swollen and sore

5. ___ My gums bleed when I brush or floss

6. ___ I have bad breath

7. ___ My mouth is dry most of the time

8. ___ I breathe through my mouth

9. ___ I have pain around my ears

___ left ___ right

10. ___ I have noise in my jaw joint

___ left ___ right

11. ___ I tend to chew on one side

___ left ___ right

12. ___ I grind my teeth while asleep

___ usually ___ frequently

___ occasionally

13. ___ I clench my teeth when stressed

14. ___ My face muscles are tired and sore

when I awake

15. ___ I have a sleep problem (snoring or apnea)

16. ___ I have a habit of biting fingernails or hard

objects

17. ___ I have a lump or swelling that needs to be

seen

18. ___ I have sore places in my mouth

19. ___ I have not replaced missing teeth

because _____

20. ___ I have noticed loose teeth or shifted

teeth resulting in gaps between teeth

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____

Please rate your smile from 1 to 10 (1=I hate my smile, 10=awesome) _____

Would you like to have whiter teeth? ___ Yes ___ No

If you could change anything about your smile, what would it be? _____

Through state of the art technology, we have the ability to simulate very closely how you would look after improvements, PRIOR to any treatment. Imaging can be performed as part of your exam visit (at NO additional Charge). Would you like to see what you would look like with a new and improved smile? ___ Yes ___ No

If yes, please check all that apply:

___ Lighten all front teeth showing

___ Lengthen

___ Eliminate dark or stained fillings

___ Lighten single tooth

___ Shorten

___ Eliminate crowding

___ Close spaces between teeth

___ Repair uneven edges

___ Reduce gum showing in smile

Please add anything you feel is important: _____