Dental Health History

(confidential)

Reason for today's visit_____

Former Dentist_____

Address_____

Date of last dental care_____ Date of last dental X-Ray_____

Check if you have had problems with any of the following:

_____Bad breath

_____Bleeding gums

_____Clicking or popping jaw, TMS

_____Food collection between teeth

_____Grinding or clench at night

_____Periodontal treatment

_____Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

Are you happy with your smile?_____ What would you change in your smile?_____

Smile Assessment

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental Team will discuss your responses with you in confidence.

I am concerned about the appearance of my teeth or my smile	YES	NO
I am concerned about the whiteness / lack of whiteness of one or more of my teeth.	YES	NO
I am concerned about the position or angle of one or more of my teeth.	YES	NO
I am concerned about the shape of one or more of my teeth.	YES	NO
In social situations, I am sometimes embarrassed by my teeth or smile.	YES	NO
There are some things about my upper front teeth that I would like to change.	YES	NO
There are some things about my lower front teeth that I would like to change.	YES	NO
I have old fillings or previous dental treatments that are no longer satisfactory to me.	YES	NO
My bite is sometimes uncomfortable when chewing or biting.	YES	NO
I am interested in learning more about esthetic dentistry.	YES	NO

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible Treatment options.

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