Dental History

- When was the last time you went to a dentist for treatment? ______________________________
- What was done at that time? ____
- What is the reason for your visit today? __________________________________
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
- Have you had braces before? ☐ Yes ☐ No
- Does dental treatment make you nervous? ☐ Yes ☐ No
- Have you had an unpleasant dental experience? ☐ Yes ☐ No
- How often do you floss? _____________________________________
- What type of toothbrush do you use? (circle one) Soft Medium Hard Electric
- What other cleaning aids, devices or rinses do you use? _________________________________

Do you experience any of the following?

- Bleeding or sore gums ☐ Yes ☐ No
- Bad breath/ unpleasant taste ☐ Yes ☐ No
- Tingling or burning tongue or lips ☐ Yes ☐ No
- Swelling or lumps in mouth ☐ Yes ☐ No
- Sores in mouth ☐ Yes ☐ No
- Food trapping between teeth ☐ Yes ☐ No
- Trouble swallowing without water ☐ Yes ☐ No
- Loose teeth ☐ Yes ☐ No
- Sensitive to hot ☐ Yes ☐ No
- Sensitive to cold ☐ Yes ☐ No
- Sensitive to sweets ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Frequent headaches ☐ Yes ☐ No
- Grinding or clenching ☐ Yes ☐ No

Smile Evaluation

	Yes	No
Are you self-conscious when you smile in front of other people or in pictures?	☐	☐
Do you ever cover your smile with your hand?	☐	☐
Do you have old filling or dental work that you don't like looking at?	☐	☐
Do you wish your teeth were whiter?	☐	☐
Do you dislike the shape of your teeth?	☐	☐
Do you have spaces between your teeth that you don't like?	☐	☐
Do you wish your teeth were straighter?	☐	☐
Are you unhappy with crowded or crooked teeth?	☐	☐

If you could wave a "magic wand" and change the appearance of you smile, how would you like it to look?

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