

# Dental History

Name: \_\_\_\_\_ Age: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Date of Last Exam and Cleaning: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Are you in pain now? Yes No If yes explain? \_\_\_\_\_

Does dental treatment make you nervous? Yes No

Do you smoke or chew tobacco? Yes No

Please check any of the following that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Deep Cleaning       | <input type="checkbox"/> Sensitivity to cold   | <input type="checkbox"/> Sores in your mouth        |
| <input type="checkbox"/> Bleeding Gums       | <input type="checkbox"/> Sensitivity to hot    | <input type="checkbox"/> Food collects b/w teeth    |
| <input type="checkbox"/> Periodontal Surgery | <input type="checkbox"/> Sensitivity to sweet  | <input type="checkbox"/> Broken fillings or teeth   |
| <input type="checkbox"/> Bad Breath          | <input type="checkbox"/> Sensitivity to biting | <input type="checkbox"/> Clench or grind your teeth |

## Cosmetic Dental Evaluation

Would you be interested in cosmetic dentistry? Yes No

When you look in the mirror are you happy with your smile? Yes No

Do you like the length and shape of your teeth? Yes No

Do you have any stains on your teeth? Yes No

Do you like the color of your teeth? Yes No

Do you have chips or cracks in your teeth? Yes No

Do you have any spaces between your teeth? Yes No

Do you have any crooked teeth? Yes No

Are you missing any teeth? Yes No

Do you have any teeth that need caps or crowns? Yes No

Would you like to change your silver fillings to tooth colored ones? Yes No

Have you ever whitened your teeth? Yes No

If yes, were you happy with the results? Yes No

Have you ever had braces in the past? Yes No

If yes, were you happy with the results? Yes No

Would you like your smile to look 10 year younger? Yes No

**Would you like to see what you would look like with a smile makeover? Yes/No**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature (Doctor): \_\_\_\_\_

Date: \_\_\_\_\_

