Dental History

Please take your time and answer all questions and honestly. This helps us care for your dental needs in the best way possible. Thank You.

Do you or have you ever had the following:

Orthodontics/Braces	**Yes**	**No**	**Oral Surgery**	**Yes**	**No**
Diseased Gums	**Yes**	**No**	**Snoring/Sleep Apnea**	**Yes**	**No**
Clicking or Popping Jaw	**Yes**	**No**	**Jaw Joint Pain**	**Yes**	**No**
Clenching or Grinding	**Yes**	**No**	**Bleeding Gums**	**Yes**	**No**
Sensitivity	**Yes**	**No**	**Bad Breath**	**Yes**	**No**
Root Canal Treatment	**Yes**	**No**	**Broken Teeth**	**Yes**	**No**

Please indicate the frequency that you do the following?

Brush_____ Floss_____ Mouthwash_____ Flouride_____

Do you have any fears or concerns about going to the dentist? Yes/No

If yes, explain_____

Are there any special requests you would like to make so we can make your visit more comfortable?_____

Do you like the appearance of your teeth and smile? Yes/No

If not, explain_____

Are your teeth all in alignment (straight)? Yes/No

If not, explain_____

Do you have spaces that you don't like? Yes/ No

If not, explain_____

Do you like the color of your teeth? Yes/No

If not, explain_____

Do you like the shape of your teeth? Yes/No

If not, explain_____

Are your teeth: Chipped, Protruding, Hidden?_____

Are there old fillings or dental work you don't like looking at? Yes/No

If yes, explain_____

What would you like to change most about the appearance of your teeth?

_____

How would you like your teeth to look?_____

_____

Would you like to see a photo of how your smile could look with Treatment?