DENTAL HISTORY

Do you have a specific dental problem? Describe ______ Yes No

Do you have dental examinations on a routine basis? Last visit? ______ Yes No

Do you think you have active decay or gum disease? ______ Yes No

Do you brush and floss on a routine basis? ______ Yes No

Do your gums ever bleed? Discuss ______ Yes No

Does food catch between your teeth? Any loose teeth? ______ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? ______ Yes No

Do you grind or brux? ______ Yes No

Have your past experiences in a dental office always been positive? ______ Yes No

Do you smoke or chew tobacco? Any sores or growths in your mouth? ______ Yes No

Discuss ______

Name of previous dentist (optional): ______

Date of last full mouth x-rays (16 small films or panoramic): ______

SMILE EVALUATION

If I could change my smile, I would:

- ☐ Make it whiter
- ☐ Make it straighter
- ☐ Close spaces between teeth
- ☐ Replace silver fillings with tooth colored restoration
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ______ DATE ______

INFORMED CONSENT

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ______ DATE ______