

Dental History

Why have you come to the dentist today? _____

Are you currently in pain or discomfort with your teeth and/or gums? Yes No

How would you describe the condition of your teeth and gums? Excellent Fair Poor

Previous Dentist: _____

Last Visit Date: _____

Have you had orthodontics? Yes No If YES, at what age? _____

Do you have headaches? Yes No If YES, how often? _____

Questionnaire

Y N Do you understand the correlation between dental plaque control and the prevention of gum disease?

Y N Do your gums ever bleed?

Y N Have you ever been told you have gum disease?

Y N Do you often feel your breath is not as fresh as it could be?

Y N Do you grind or clench your teeth?

Y N Have you ever had pain/discomfort in your jaw joint?

Y N Do you snore or have you been told you do?

Y N Do you sleep well? How long? _____

Y N Would you like to have whiter teeth?

Y N Would you like your teeth to be straighter?

Y N Are you unhappy with any silver or discolored fillings?

Y N Do you have crowns or bridges which are unattractive or unnatural looking?

Y N Do you sometimes feel uncomfortable with the appearance of your smile?

Y N Are your teeth crooked or crowded?

Y N Do you think a more attractive smile would improve your personal and/or professional relationships?

Y N Are you afraid or anxious to visit the dentist?

Y N Do you wish that you could feel relaxed at your next dental appointment?

What level of dental care do you think your dental insurance company will cover? Excellent Fair Poor

What level of dental care would you like to have for yourself? Excellent Fair Poor

The information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize any photographs or slides to be taken of me during treatment at Creative Smiles for educational purposes, laboratory fabrication, or internal office use. I fully understand that other dentists, team members, and other patients may view these photos for educational and / or treatment purposes.

Signature: _____

Date: _____