Welcome to our office. In order to serve your dental needs better please review and fill out the following survey of your dental history.

Name____ Todays Date________________________

What brought you to the office today?____

Are you having any problems that require immediate attention? ___________________________________

When was your last visit to a dentist?_____________ what for?____________________

How often do you go to the dental office?____

Do any of the following cause you to have tooth discomfort?

Hot__________ Cold _________Biting down _____________chewing?___________ other?_____________

How often do you brush your teeth?_____________ floss? _______________Water Jet?________________

Do your gums bleed?_________________________When?____

Do your gums ever feel tender or swollen?____

Have you ever had periodontal treatment? ___________________when_____________________________

Have you ever had a TMJ problem? ____

Do you clench or grind your teeth?__________________ Do you have a night guard?

Do your jaws ever ache or get tired?______________

Does your joint make noise? Click____________ Pop______________ Crunch? ________________________

Do you get headaches? _______________Earaches? _______________Neck aches?____________________

Have you ever had orthodontic treatment? _________Conventional Braces or Invisalign?______________

Do you have any loose or broken fillings?____

Do you have any loose or broken teeth?____

Have your teeth shifted or become worn ____

Do you have any food traps?____

Do you have any missing teeth?____

Do you have any Crowns?_______ fixed bridges?______________ dental implants?_______________

Do you have removable Full or partial Dentures?___________________________

Do you like the appearance of your smile?____

Have you ever had any cosmetic dental procedures?_____________ What was done? _______________

Are you happy with the result?____

Do you have concerns about? (please check all that apply)

- ☐ Gaps or Spaces between Teeth
- ☐ Color of Teeth
- ☐ Shape of Teeth
- ☐ Size of Teeth
- ☐ Show too much Gum
- ☐ Symmetry of Teeth
- ☐ Position of Teeth (crooked or crowded)
- ☐ Teeth Chipped or Broken
- ☐ Discolored Restorations (i.e. existing crowns, fillings, bonding)
- ☐ Front Teeth
- ☐ Back Teeth
- ☐ Inflamed or Bleeding Gums

Is there any other information that you think might help us in evaluating your dental needs?

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