

Medical Information

• Are you now under the care of a physician? Physician Name: _____	Yes	No	Don't Know
Address/City/State/Zip _____	Physician Phone: _____		
• Are you in good health?	Yes	No	Don't Know
• Has there been any change in your general health within the past year? If yes, what condition is being treated? _____	Yes	No	Don't Know
• Date of last physical exam: _____			
• Have you had a serious illness, operation or been hospitalized in the past five years?	Yes	No	Don't Know
• Are you taking or have you recently taken any prescription or over the counter medications?	Yes	No	Don't Know
Please list all medications, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____			

Dental Information

Please circle yes, no or don't know:

• Do your gums bleed when you brush or floss?	Yes	No	Don't Know
• Are your teeth sensitive to cold, hot, sweets or pressure?	Yes	No	Don't Know
• Does food or floss catch between your teeth?	Yes	No	Don't Know
• Is your mouth dry?	Yes	No	Don't Know
• Have you had any periodontal (gum) treatments?	Yes	No	Don't Know
• Have you ever had orthodontic (braces) treatment?	Yes	No	Don't Know
• Have you had any problems associated with previous treatment?	Yes	No	Don't Know
• Is your home water supply fluoridated?	Yes	No	Don't Know
• Do you drink bottled or filtered water?	Yes	No	Don't Know
• Are you currently experiencing dental pain or discomfort?	Yes	No	Don't Know
• Do you have earaches or neck pains?	Yes	No	Don't Know
• Do you have any clicking, popping or discomfort in the jaw?	Yes	No	Don't Know
• Do you brux or grind your teeth?	Yes	No	Don't Know
• Do you have sores or ulcers in your mouth?	Yes	No	Don't Know
• Do you wear dentures or partials?	Yes	No	Don't Know
• Do you participate in active recreational activities?	Yes	No	Don't Know
• Have you ever had a serious injury to your head or mouth?	Yes	No	Don't Know
• Date of your last dental exam: _____			
• Date of last dental x-rays: _____			
• What was done at that time? _____			
• What is the reason for your dental visit today? _____			

Smile Information

Please circle yes or no:

• Do you like the appearance of your teeth; your 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 your teeth wearing on the biting surfaces?	Yes	No	If not, explain _____
• Are there old fillings or dental work you don't like looking at?	Yes	No	If not, explain _____
• What would you like to change the most in the appearance of your teeth? _____ _____			
• How would you like your teeth to look? _____			

