

AESTHETIC PLUS

THE SMILE MAKEOVER

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental Visit _____ Last Dental Cleaning _____

Last Full Mouth X-rays _____

What was done at your last dental visit?

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations _____

How often do you brush your teeth? _____

How often do you floss? _____

What other dental aids do you use? (Sonicare, toothpick, etc.)

Do you have any dental problems now? Yes No
If yes, please describe:

Is there anything else about having dental treatment that you would like to know?
If yes, please describe _____

ARE ANY OF YOUR TEETH SENSITIVE TO

- Hot or cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No
- Have you noticed your mouth odors or bad taste? Yes No
- Do you frequently get cold sores, blister or any other lesions? . Yes No
- Do your gums bleed or hurt? Yes No
- Have your parents experienced gum disease or tooth loss? . Yes No
- Have you noticed any loose teeth or change in your bite? . Yes No
- Does food tend to become caught in between your teeth? Yes No
If yes, Where? _____

DO YOU:

- Clench or grind your teeth while awake or sleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? Yes No
(pencils, pipe, pins, nails, fingernails)
- Mouth breathe while awake asleep? Yes No

HAVE YOU EVER HAD:

- Orthodontic treatment? Yes No
- Oral Surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- If so, please describe, including cause _____

HAVE YOU EVER EXPERIENCED:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Diffi culty in opening or closing the mouth? Yes No
- Diffi culty in chewing on either side of the mouth? Yes No
- Headaches, neck aches or shoulder aches? Yes No
- Sore muscles (neck, shoulders) Yes No
- Are you satisfi ed with your teeth's appearance? Yes No
- Would you like to keep all of your teeth all of your life? Yes No
- Do you feel nervous about having dental treatment? Yes No
- If so, what is your biggest concern? _____
- Have you ever had an upsetting dental experience? Yes No
- If yes, please describe _____

- Have tired jaws especially in the morning? Yes No
- Smoke/Chew tobacco? Yes No

If you could have a magic wand and change anything about your smile, what would it be?
