# PATIENT DENTAL HISTORY AND SMILE EVALUATION

Patient's Name________________________________Date of Birth____________________

Reason for this visit___________________________________________________________

When was your last dental visit?__________What was done then?_____________

Previous Dentist (name and location)____________________________________________

How often do you brush and floss your teeth?_____________________________________

Do your gums bleed when brushing and flossing?__________________________________

Do you have any teeth that are sensitive?________________________________________

Do clench or grind your teeth?________________________________________________________

Have you noticed any loosening of your teeth?____________________________________

Have you experienced any jaw pain (clicking in the jaw, pain in the joint, difficulty opening or closing, chewing) ______________________________________________________

Do you have frequent headaches?______________________________________________

Do you like the way your teeth look?____________________________________________

If you could change anything about your smile, what would it be? Please check below

Color? Yes___ No___ Straighter? Yes _____ No___

Shape? Yes___ No___ Close Spaces? Yes___ No___

Replace Missing Teeth? Yes____ No___ Replace Old Silver Fillings? Yes___ No___

What is your vision and ultimate goal for your smile?_____________________________________

____________________________________________________________________________________

Date_______________