MEQUON SMILE DESIGN

Patient First Name _____ Patient Last Name _____ Date _____

DENTAL HEALTH HISTORY

DENTAL INFORMATION

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name | _____

How long were you a patient there | _____

Date of most recent exam an cleaning | _____

Date of most recent x-rays | _____

I routinely see my dentist every | ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

On a Scale from 1 - 10, with 10 being the highest rating |

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Are you fearful of the dentist? ..... Yes or No

If yes, how fearful?..... 1 2 3 4 5 6 7 8 9 10

What is your immediate concern | _____

PERSONAL HISTORY, *Check all that apply*

- ☐ Had an unfavorable dental experiene
- ☐ Had/ have braces, orthodontic treatment
- ☐ Had complications from past dental treatment
- ☐ Had your bit adjusted
- ☐ Had trouble getting numb
- ☐ Have / had any teeth removed
- ☐ Had any reactions to local anesthetic
- ☐ Fear or Anxitey about Dental Treatment

SMILE CHARACTERISTICS, *Check all that apply*

- ☐ Make my teeth whiter
- ☐ Close space / gaps that bother me
- ☐ Replace missing teeth
- ☐ Dissatisfied with appearance of my teeth
- ☐ Make my teeth straighter
- ☐ Repair chipped teeth
- ☐ Have a smile make over

TOOTH, STRUCTURE, *Check all that apply*

- ☐ Cavities in the past 3 years
- ☐ Dry Mouth
- ☐ Chipped tooth
- ☐ Dental Implants
- ☐ Root Canals
- ☐ Difficulty swallowing food
- ☐ Sensitivity to Hot Cold Sweets
- ☐ Dentures or Partials
- ☐ Crowns
- ☐ Loose Teeth

BITE AND JAW JOINT, *Check all that apply*

- ☐ Jaw Joint Pain
- ☐ Uncomfortable when I bite my teeth
- ☐ Teeth crowding
- ☐ Clicking or popping of the Jaw
- ☐ Difficulty opening and chewing
- ☐ Wear or wear a bite appliance
- ☐ Chewing problems
- ☐ Grinding or clenthing teeth
- ☐ Develping spaces
- ☐ Sleep problems
- ☐ Frequent headaches
- ☐ Jaw Surgery

GUM AND BONE, *Check all that apply*

- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Lost bone around your teeth
- ☐ History of periodontal disease in your family
- ☐ Experience a burning sensation in your mouth
- ☐ Periodontal Disease or Gum Treatments
- ☐ Unpleasent odor or taste in mouth
- ☐ Gum recession