Dental History

To aid in our diagnosis and treatment of your esthetic concerns and to prepare your Personalized Dental Plan, please take a moment to answer the following questions.

Do you dislike the color of your teeth?	YES	NO
Have you whitened your teeth? If so, how?_____	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too short or too long?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work that you consider "ugly"?	YES	NO
Are you self-conscious of your teeth and/or smile?	YES	NO
Has anyone (family member or friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a "new smile"?	YES	NO
Are you interested in knowing what your cosmetic options are?	YES	NO

TMJ issues

Please rate your current degree of comfort or discomfort as:

"1" no pain and "10" worst possible pain/discomfort

TMJ clicking/grating	____
TMJ locking/stiffness	____
Inability to open mouth	____
Mouth doesn't open straight	____
Pain when eating/chewing	____
Pain in jaw or jaw joint	____
Unstable bite	____
Headaches	____
Face pain	____
Neck pain	____
Ear pain/ stiffness	____
Ringing in ears	____
Difficulty swallowing	____
Throat pain	____
Other_____	____
Other_____	____