1. What is your main concern and/or goal in dentistry?

2. Do you think you have a healthy mouth? If no, why?

3. Are you interested in improving the appearance of your smile in general or a specific area in your smile? If yes, please describe your goals.

4. Are you interested in whitening your teeth? Yes No
5. Who was your previous dentist and why did you leave that office?

6. Have you had any problems or complications while getting dentistry done?

7. Are you aware of any problems in your mouth? Yes No
   If yes, please describe:

8. When was your last dental appointment?

9. When were your teeth last cleaned?

10. Do you clench or grind your teeth? Yes No
11. Does your jaw click or pop? Yes No If yes does it hurt? Yes No
12. Do you have any pain in the muscles of your jaw?
13. Has a bite/night guard ever been suggested to you? Yes No
    If yes do you have one now? Yes No
14. Do you have an area where food gets caught? Yes No
    If so where?_____
15. Have you ever had gum surgery or treatment? Yes No
16. Have you had orthodontic treatment? Yes No
17. Is there anything else we should know?

18. What can our office do for you to make dentistry a better experience?

Dental History