SPEAR AESTHETICS

DENTAL HEALTH

Name:_____ Date:_____

Please describe your immediate concern, followed by any other problems, concerns or questions: _____

_____

_____

_____

Personal History

Approximate date of last dental visit: _____When were your teeth last cleaned professionally?

YES NO Are you fearful of dental treatment?
YES NO Have you had an unfavorable dental experience?
YES NO Have you ever had complications from past dental treatment?
YES NO Have you had trouble getting numb or had any reactions to local anesthetic?
YES NO Have you had any braces, orthodontics or has your bite been adjusted?
YES NO Have you had any teeth removed?

Gum & Bone

How many times/day do you Brush? _____ How often do you floss?_____ Type of toothbrush: (circle) MANUAL ELECTRIC

YES NO Do your gums bleed or are they painful when brushing / flossing?
YES NO Have you ever been treated for gum disease or been told you have bone loss around teeth?
YES NO Is there anyone with a history of periodontal disease in your family?
YES NO Have you ever noticed an unpleasant taste or odor in your mouth?
YES NO Have you ever experienced any gum recession?
YES NO Have you experienced a burning sensation in your mouth?
YES NO Do you have teeth that have become loose on their own?

Tooth Structure

Are your teeth sensitive to any of the following? (circle all that apply) HOT COLD BITING SWEETS BRUSHING

YES NO Have you had cavities within the past 3 years?
YES NO Do you frequently get food caught between your teeth?
YES NO Do you feel or notice any holes (i.e. pits or craters) on the biting surfaces of your teeth?
YES NO Do you have grooves or notches near the gum line?
YES NO Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?

Bite & Jaw Joint

Do you have problems with your jaw joint? (circle) PAIN NOISE LIMITED OPENING LOCKING POPPING

YES NO Do you feel like your lower jaw is being pushed back when your teeth are together?
YES NO Does your jaw feel tired eating hard or chewy foods?
YES NO Have your teeth changed in the past 5 years, become shorter, thinner or worn?
YES NO Are your teeth becoming crowded or developing spaces?
YES NO Do you have more than one bite to make your teeth fit together?
YES NO Do you chew ice, bite your nails, use your teeth to hold objects, or have any oral habits?
YES NO Do you clench your teeth during the daytime or make them sore?
YES NO Do you have any problems with sleep or wake up with an awareness of your teeth?
YES NO Have you ever worn an oral appliance?

Smile Characteristics

YES NO Is there anything about the appearance of your teeth that you would like to change?
YES NO Have you ever whitened (bleached) your teeth? If YES, when was the last time? _____
YES NO Have you ever felt self-conscious about the appearance of your teeth?
YES NO Have you been disappointed with the appearance of previous dental work?