SMILES·NY
COSMETIC AND IMPLANT DENTISTRY

220 EAST 63RD STREET
LOBBY F
NEW YORK, NY 10065

Date:_____

Dental Information

Last Name: _____ First Name:_____ M.I._____

Your Dental History

What is the reason for your visit today?_____

_____

What is the date of your last dental visit?_____

Does dental work make you anxious?_____	Yes	No
Have you had any bad experiences at the dentist?_____	Yes	No
Have you ever had problems with dental anesthetics?_____	Yes	No
Do you have any allergies related to dental work?_____	Yes	No
Do your gums bleed while brushing, flossing, or on their own?_____	Yes	No
Have you ever been diagnosed with gum disease?_____	Yes	No
Are any of your teeth loose?_____	Yes	No
Are any of your teeth sensitive to hot and/or cold?_____	Yes	No
Have you ever had braces?_____	Yes	No
Have you had your wisdom teeth removed?_____	Yes	No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	Yes	No
Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	Yes	No
Do you avoid or have difficulty chewing gum, carrots , nuts, bagels, or other hard, dry food?_____	Yes	No
Have your teeth changed in the last 5 years, have they become shorter, thinner or worn?_____	Yes	No
Are your teeth becoming more crooked, crowded, or overlapped?_____	Yes	No
Do you have more than one bite, squeeze, or do you shift your jaw to make your teeth fit together?	Yes	No
Do you place your tongue between your teeth or rest your teeth against your tongue?_____	Yes	No
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	Yes	No
Do you clench your teeth in the daytime, or do they feel sore?_____	Yes	No
Do you have any problems with sleep, wake up with a headache, or an awareness of your teeth?_	Yes	No
Do you wear or have you ever worn a bite appliance?_____	Yes	No
Are you happy with your smile?_____	Yes	No
Are you happy with the color of your teeth?_____	Yes	No
Are you interested in what cosmetic dentistry can do for your smile?_____	Yes	No

Please list what you would like to change about your smile:

_____

_____

Please tell us any other concerns you have about your dental treatment:_____

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