Print Form

Dental History

Do you suffer from any of the following:

Y	N	
○	○	**clenching or grinding of teeth**
○	○	**frequent headaches**
○	○	**popping jaw**
○	○	**pain when chewing**
○	○	**sensitivity to hot or cold.**
○	○	**sensitivity to sweets**

Do you wear a night guard? _____.

How happy are you with your smile today?
(on a scale of 1 to 10) 1=help-10=love it ☐ _____.
What if anything would you change about your smile?
_____.
Have you ever received a comprehensive evaluation? _____.
(study models, photos and a tooth by tooth explanation of how to improve your overall dental health and appearance)

Do you use a manual or electric toothbrush?
Have you whitened your teeth before? ☐ If so: ☐ over-the-counter / ☐ custom trays.

I (○ Do / ○ Do not) give consent to share my dental photo's with other individual's for the purpose of treatment education.

In an effort to accommodate all our patients as well as continue to provide affordable dentistry,
We require a 24 hour notice of cancellation or change of appointment.
There will be a **$25.00** fee attached to each *missed* or *cancelled* appointment when proper notification is not provided.

Name _____Date ☐