OralDynamics
Advanced Dental Esthetics

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Internal Use Only: __/__/___
#/Name_____
FMX_____
BWX_____
Other_____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____

Name of previous dentist: _____ Location: _____

Permission to contact previous dentist for records/x-rays? Yes ____ No ____ Date of last full mouth x-rays: _____

Do you have dental exams on a routine basis? Yes ____ No ____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

Would you like to keep your remaining teeth? Yes ____ No ____ Do you have sores or growths in your mouth? Yes ___ No ___

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? Yes ___ No ___

If yes, please explain: _____

What if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth: _____ Manual or Powered Toothbrush: _____ How often do you floss: _____

Do you avoid brushing any part of your mouth because of pain? Yes ____ No ____ If yes, what part? _____

Which foods cause you twinges of pain: Hot ____ Cold ____ Sweet ____ Sour ____ None ____

Do your gums feel tender or swollen? Yes ____ No ____ Do your gums ever bleed? Yes ____ No ____

Do you chew on only one side of your mouth? Yes ____ No ____ If yes, please explain: _____

Does food catch between your teeth? Yes ____ No ____ Any loose teeth? Yes ____ No ____

Do you clench or grind your jaws while sleeping or during the day? Yes ____ No ____

Do your jaws ever feel tired? Yes ____ No ____ Do you have clicking, popping, or discomfort? Yes ____ No ____

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? Yes ____ No ____ Why? _____

Please rate your smile from 1 to 10 (1=strongly dislike, 10=awesome): _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

_____

Do you have any special occasion coming up? _____

What (if any) foods are you unable to eat that you enjoy most? _____

If you had a magic wand, what, if anything would you change about you smile? *Please check all that apply…*

____ Lighten all front teeth showing	____ Rebuild fractures	____ Straighten rotation
____ Lighten single tooth	____ Lengthen	____ Straighten angulation
____ Close spaces between teeth	____ Shorten	____ Eliminate crowding
____ Eliminate dark or stained fillings	____ Repair uneven edges	____ Reduce gum showing in smile

Please add anything you feel is important: _____