759 Newtown-Yardley Road
Newtown, PA 18940

DENTAL HEALTH & APPEARANCE

Date ___________________________________

Reason for visit ____

Approximate date of last dental visit ____

What is your primary oral health concern we should address first? ____

When would you like us to start treatment? ____

Have you ever had any serious problem associated with previous dental treatment, or had any dental emergencies?

❑ Y ❑ N – If so, please explain: ____

What, if anything, has happened during previous experience to cause you not to return to your dentist?

____

Do you ever feel, or have you ever been told, that you don't have fresh breath? _____________________________

How often do you brush your teeth? _______ times per __________. Floss? _______ times per _______.

What type of toothbrush do you use? ❑ Manual ❑ Powered ____

Do you avoid brushing any part of your mouth due to pain? ❑ Yes ❑ No If so, where? _______________________

Do any of the following food types cause you twinges of pain? ❑ Hot ❑ Cold ❑ Sweet ❑ Sour ❑ None

Do your gums feel tender or swollen? ❑ Yes ❑ No If so, where? ____

Do you chew on only one side of your mouth? ❑ Yes ❑ No If so, please explain: ___________________________

Do you clench or grind your teeth while sleeping or awake? ❑ Yes ❑ No

Do your jaws ever feel sore, achy or tired? ❑ Yes ❑ No Please explain: ___________________________________

COSMETIC / ESTHETIC EVALUATION

Are you delighted with your smile? ❑ Y ❑ N Please rate your smile from 1-10 (1 = hate it, 10 = love it) ______________________

Would you like to have whiter teeth? ❑ Y ❑ N

If you had a magic wand, what (if anything) would you change about your smile? ____

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

Do you have any special occasions coming up? ____

Through state-of-the-art technology in cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight. Using Dental Imaging and Digital Photography, we can simulate very closely how you would look after such improvements, PRIOR TO any actual treatment! Imaging can be performed as part of your exam visit (at no additional charge). Would you like to see what you would look like with a new and improved smile? ❑ Yes ❑ No **If yes, please select all that apply:**

❑ Lighten all visible front teeth	❑ Rebuild fracture(s)	❑ Straighten rotation	❑ Eliminate dark or stained fillings
❑ Lighten single tooth	❑ Lengthen	❑ Straighten angulation	❑ Reduce gum showing in smile
❑ Close spaces between teeth	❑ Shorten	❑ Eliminate crowding	❑ Repair uneven edges

Please add anything you feel we should know: