

Dental Health

What is your primary reason for being here today? _____

When was your last dental visit? _____ What was done? _____

Name and city of former dentist _____

Whom may we thank for referring you to Lake Baldwin Dental? _____

Describe in your own words, how we may help you: _____

Unpleasant experience with dentist(s) in past (describe) _____

- | | | | | | |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|-------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you been under regular care by a dentist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are your teeth sensitive to sweets? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are your teeth sensitive to temperature? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any loose teeth? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do any of your teeth ache? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do your gums bleed or have pain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do your gums feel tender or swollen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you clench or grind your teeth? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you notice popping in your jaw? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you tense during dental visits? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you happy with the appearance of your teeth? | | | |

Yes No Would you be interested in learning more about oral sedation?

Yes No Would you be interested in learning more about the treatment for snoring or sleep apnea?

Smile Analysis

- | | |
|--|---|
| <input type="checkbox"/> I wish my teeth were whiter | <input type="checkbox"/> I grind my teeth to where the biting edges are chipped |
| <input type="checkbox"/> I wish my teeth were straighter | <input type="checkbox"/> When I smile, I show too much gum |
| <input type="checkbox"/> I think my smile shows too much space between my teeth | <input type="checkbox"/> I have gray, black, silver fillings that show when I smile |
| <input type="checkbox"/> I am sometimes hesitant to smile | <input type="checkbox"/> My old crowns have dark edges and don't look natural |
| <input type="checkbox"/> Some of my teeth appear short and fat OR too small or too large | <input type="checkbox"/> I am concerned about the cost of enhancing my smile |

How do you rate your smile on a scale of 1-10, with 10 being the best smile? _____

I would like to learn more about enhancing my own smile with cosmetic dentistry

Consent for Procedure

I certify that all of the above medical and dental information is true to my knowledge and that I have not omitted any pertinent information. I consent to the performing of dental or oral surgery procedures agreed to be necessary and advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I wish to assign any benefits under my dental insurance policy to Lake Baldwin Dental, PA if applicable. I will assume responsibility for all fees associated with any procedures and costs incurred from my dental treatment. Further, I consent to allow my clinical photographs to be used by the doctors in an educational environment.

Patient's (Parent's) signature _____ Date _____

Doctor's signature _____ Date _____