

Dental Health

What is your chief reason for being here? _____

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

Name and address of former dentist _____

Why did you leave your last dentist? _____

On a scale of 1-10 (10 being the highest) what priority do you give your teeth? _____

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

Previous dental experiences

- Unpleasant experience with dentist(s) in past (describe) _____
- Pleased with previous dental experience

Self Analysis

- | | |
|---|--|
| <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 Have you had any teeth removed? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are your teeth sensitive to sweets? | <input type="checkbox"/> Yes <input type="checkbox"/> No Were there any complications? |
| <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? | |

Describe in your own words, your present dental problem: _____

Attitudes

- Yes No Are you deeply concerned about finances required to return your mouth to excellent dental health?
- Yes No Do you want to learn to control dental disease and retain your teeth?

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

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.

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

Doctor's signature _____ Date _____