Dental Health History

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 Anderson Dental Associates? _____

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

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

□Yes□No Have you been under regular care by a dentist?

□Yes□No Are your teeth sensitive to sweets?

□Yes□No Are your teeth sensitive to temperature?

□Yes□No Do you have any loose teeth?

□Yes□No Do any of your teeth ache?

□Yes□No Do your gums bleed or have pain?

□Yes□No Do your gums feel tender or swollen?

□Yes□No Do you clench or grind your teeth?

□Yes□No Do you notice popping in your jaw?

□Yes□No Are you tense during dental visits?

□Yes□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

□ I wish my teeth were whiter

□ I grind my teeth to where the biting edges are chipped

□ I wish my teeth were straighter

□ When I smile, I show too much gum

□ I think my smile shows too much space between my teeth

□ I have gray, black, silver fillings that show when I smile

□ I am sometimes hesitant to smile

□ My old crowns have dark edges and don't look natural

□ Some of my teeth appear short and fat OR too small or too large

□ 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 Anderson Dental Associates 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 _____