SmilesNY
Cosmetic & Implant Dentistry
212.752.6537

220 EAST 63RD STREET
LOBBY F
NEW YORK, NY 10065

Date:_____

# Dental Information

Last Name: _____ First Name:_____ M.I._____

## Your Dental History

What is the reason for your visit today?_____

_____

What is the date of your last dental visit?_____

| | | |
|---|---|---|
| Does dental work make you anxious?_____ | Yes | No |
| Have you had any bad experiences at the dentist?_____ | Yes | No |
| Have you ever had problems with dental anesthetics?_____ | Yes | No |
| Do you have any allergies related to dental work?_____ | Yes | No |
| Do your gums bleed while brushing, flossing, or on their own?_____ | Yes | No |
| Have you ever been diagnosed with gum disease?_____ | Yes | No |
| Are any of your teeth loose?_____ | Yes | No |
| Are any of your teeth sensitive to hot and/or cold?_____ | Yes | No |
| Have you ever had braces?_____ | Yes | No |
| Have you had your wisdom teeth removed?_____ | Yes | No |
| Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ | Yes | No |
| Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ | Yes | No |
| Do you avoid or have difficulty chewing gum, carrots , nuts, bagels, or other hard, dry food?_____ | Yes | No |
| Have your teeth changed in the last 5 years, have they become shorter, thinner or worn?_____ | Yes | No |
| Are your teeth becoming more crooked, crowded, or overlapped?_____ | Yes | No |
| Do you have more than one bite, squeeze, or do you shift your jaw to make your teeth fit together? | Yes | No |
| Do you place your tongue between your teeth or rest your teeth against your tongue?_____ | Yes | No |
| Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____ | Yes | No |
| Do you clench your teeth in the daytime, or do they feel sore?_____ | Yes | No |
| Do you have any problems with sleep, wake up with a headache, or an awareness of your teeth?__ | Yes | No |
| Do you wear or have you ever worn a bite appliance?_____ | Yes | No |
| Are you happy with your smile?_____ | Yes | No |
| Are you happy with the color of your teeth?_____ | Yes | No |
| Are you interested in what cosmetic dentistry can do for your smile?_____ | Yes | No |

Please list what you would like to change about your smile:_____

_____

_____

Please tell us any other concerns you have about your dental treatment:_____

_____

_____