Welcome to the Dental Office of David J. Weiner, D.M.D., P.A.

Dental History and SMILE Evaluation Form

Our goal is to help you achieve your best oral health and most beautiful smile. Please answer the following questions so that we may optimize your dental experience with our practice.

Date_____

Patient's name _____ _____

Previous Dentist _____ **Date of last visit**_____

What concerns you most about your teeth?

_____

_____

Please circle Yes or No (If Yes, please explain.)

Yes No Are you having any dental pain or discomfort at this time? _____
Yes No Do you feel nervous about having dental treatment? _____
Yes No Have you ever had a bad experience in a dental office?_____
Yes No Have your wisdom teeth been removed? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever smoked or chewed tobacco?_____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes No Are you aware of your jaw clicking or popping?_____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No Do you have old fillings and dental work you don't like looking at?_____

How do you feel about the color of your teeth?_____
_____

How do you feel about the alignment (straightness) of your teeth? _____
_____

What is your attitude toward orthodontic treatment? _____
_____

How do you feel about the overall appearance of your teeth and smile?_____
_____

Do you have spaces you don't like? Please explain._____
_____

What would you like **most** to change about the appearance of your teeth? _____
_____
_____

How would you like your teeth to look?_____
_____

Is there anything else you would like to tell us?_____
_____
_____
_____