Smiles

Welcome to Smiles by Dr. Goodlin & Dr. Shasha

______________________________ ____/____/____

First Name Last Name Today's Date

ABOUT YOU

Who referred you? ______________________________

Contact info ____________________ ____________________ ____________________

I like to be called | email address | Cell Phone Number

____________________ __________ ______________ ______________

Street address | Postal Code | Home Phone number | Work Phone number

____________________ ____________________ ____________________

Name of Employer | Job Description | Hobbies and interests

____/____/____ ____________________ ____________________

Birthday | Name of spouse | Name of children

DENTAL HISTORY Please ☑ YES or NO to each question.

	Question	YES	NO
1.	Reason for today's visit ❑ Exam ❑ Cleaning ❑ Emergency ❑ Other		
	Are you presently having dental pain?	❑	❑
	Is there a dental problem you would like to take care of as soon as possible?	❑	❑
2.	How frequently do you see your dentist? ❑ 6 months ❑ Yearly ❑ Other? ____________		
	Previous Dentist: ____________ Last dental visit: ____________		
	Last cleaning: ____________ Full mouth series of x-rays: ____________		
3.	How frequently do you brush your teeth? ________ Floss? ________ Do you feel you have bad breath?	❑	❑
4.	Do your gums bleed easily?	❑	❑
5.	Are your teeth sensitive to: ❑ Hot ❑ Cold ❑ Biting ❑ Sweets?	❑	❑
6.	Do you smoke or use any other form of tobacco?	❑	❑
7.	Have you ever had jaw joint surgery?	❑	❑
8.	Do you have pain in your jaw joints or suffer from migraine headaches?	❑	❑
9.	Does any part of your mouth hurt when clenched?	❑	❑
10.	Does your jaw crack or pop when opened widely?	❑	❑
11.	Have you had: ❑ Braces ❑ Oral Surgery ❑ Gum Treatment ❑ Root Canal?	❑	❑
12.	Do you have trouble sleeping? Sleep Apnea? Do you snore?	❑	❑
13.	Do you have a night time appliance you wear?	❑	❑
14.	Do you grind or clench your teeth during the day or night?	❑	❑
15.	Have you ever experienced any growths or sore spots in your mouth? If so, where?	❑	❑
16.	Previous problems with dental treatment?	❑	❑
17.	Are you satisfied with the appearance of your teeth?	❑	❑
18.	Please list any other dental concerns or questions? ____________		