SHAHRAM SHEKIB, DDS, FAGD, PC

LASER AESTHETIC SURGERY • PORCELAIN VENEERS • INVISALIGN • IMPLANT DENTISTRY

DENTAL HEALTH HISTORY

Last Name _____ First Name _____ Date of Birth _____Today's Date _____

Date of Last Dental Exam _____

Who is your / your child's dentist: Name _____

Address_____ Phone (_____)_____

Are you / your child being treated for any dental condition now? _____ Recent Surgery? _____

_____

What Concerns you the most? _____

1. Do you have any pain or sensitivity to hot, cold or sweets? [*Please Specify*] _____
2. Do you have any pain or soreness in any part of your mouth? [*Please Specify*] _____
3. Do you often get food impaction between your teeth? [*Please Specify*] _____Do you have gum recession? _____
4. Do your gums bleed, either in chewing or brushing or at any other time? [*Please Specify*] _____
5. Do you clench your teeth during the day? Have you been aware of clenching your teeth during the night? _____
6. How often do you brush your teeth? _____ Do you brush your teeth vigorously or lightly? _____
7. Do you floss your teeth? How often? _____ Do you brush your tongue? _____
8. Do you use any type of electrical brush or electrical flosser? [*Please Specify*] _____
9. Do your gums feel irritated, tender, swollen or bleed upon brushing? _____
10. Were you ever diagnosed with gum disease [Periodontal disease] ? _____ If so, did you ever receive treatment for it? _____
11. Have you ever had any complication with dental anesthesia – Increase Heart Rate? Fainting? [Please Specify] _____
12. Do you wear Night Guard, Retainer or any kind of dental device? _____
13. Did you ever have Root Canal Therapy? _____ Did you ever have orthodontic treatment? _____
14. Do you have any dental implants, Porcelain Veneers, Crowns or Bridge Restorations? _____
15. Do you have any missing teeth? _____ Were you ever told why your missing teeth should be replaced? _____
16. Do you have any loose or fractured fillings or restorations?_____
17. Do you wear dentures? _____ Do you feel that dentures are inevitable? _____
18. How often do you have deep cleaning? Every _____ months or Every _____ year.
19. Do you suffer from bad Breath? _____Do you suffer from dry mouth? _____
20. Do you want to keep your own teeth as long as possible? _____

SMILE EVALUATION

1. Do you like the way your teeth look? [*Please Explain*] _____
2. Are you happy with the color of your teeth? [*Please Explain*] _____
3. Would you like for your teeth to be whiter? [*Please Explain*] _____
4. Would you like your teeth to be straighter? [*Please Explain*] _____
5. Do you have spaces between your teeth that you would like to be closed? [*Please Explain*] _____
6. Would you like your upper teeth to be longer? [*Please Explain*] _____
7. Do you like the shape of your teeth? [*Please Explain*] _____
8. Do you have missing teeth that you would like to be replaced? [*Please Explain*] _____
9. Do you have old silver fillings that you would like replaced with tooth-colored ones? [*Please Explain*] _____
10. Do you believe in preventive dentistry? *[Please Explain]* _____
11. If you could change anything about your smile, what would you change? [*Please Explain*] _____

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient