How would you rate the condition of your mouth?	Previous Dentist	DENTAL HISTORY	
Iroutinely see my dentist every:	Iroutinely see my dentist every:	Previous Dentist How long were you a patient?	
PLEASE ANSWER YES OR NO TO THE FOLLOWING:  PERSONAL HISTORY  1. Are you fearful of dental treatment? Scale of 1 to 10 (very). 2. Have you ever had an unfavorable dental visit? 3. Do you prefer to use Nitrous Oxide with dental treatment? cleaning? 4. Have you ever had complications from past dental treatment? 5. Have you ever had trouble getting numb or reactions to local anesthetic? 6. Did you ever have braces, orthodontic treatment or had your bite adjusted? 7. Have you had any teeth removed?  SIMILE CHARACTERISTICS 8. Is there anything about the appearance of your teeth that you would like to change? 9. Have you ever whitened (bleached) your teeth? 10. Are you self-conscious about your teeth? 11. Have you been disappointed with the appearance of previous dental work?  BITE AND JAW JOINT 12. Do you I would you have any problems chewing gum? 13. Do you Jaw you do you have any problems with chewing bagels or other hard food? 14. Have your teeth changed in the last 5 years, become shorter, thinner or worm? 15. Are your teeth rowding or developing spaces? 16. Do you wave problems with your jaw joint? (pain, sounds, limited opening, locking, or popping) 17. Do you wave problems with your jaw joint? (pain, sounds, limited opening, locking, or popping) 18. Do you wave or have you ever worm a bite appliance, splint or nightguard?  10. Have you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping) 19. Do you wave or have you ever worm a bite appliance, splint or nightguard?  10. Day un wave or have you ever worm a bite appliance, splint or nightguard?  10. Day ou wave or have you ever worm a bite appliance, splint or nightguard?  10. Day ou wave or have you ever worm a bite appliance, splint or nightguard?  10. Day ou wave or have you ever worm a bite appliance, splint or nightguard?  10. Lave you teeth benoming loses? 10. Day our your been the sensitive to hot, cold, biting, or sweets? 11. Have you ever reperienced a burning sensation in your mouth? 12. Learny or over the normal splin	PLEASE ANSWER YES OR NO TO THE FOLLOWING:  PERSONAL HISTORY  1. Are you fearful of dental treatment? Scale of 1 to 10 (very)	Date of most recent treatment (other than cleaning)/	
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PERSONAL HISTORY  1. Are you fearful of dental treatment? Scale of 1 to 10 (very)	PERSONAL HISTORY  1. Are you fearful of dental treatment? Scale of 1 to 10 (very)	WHAT IS YOUR IMMEDIATE CONCERN?	
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