Dental History & TMJ Questionnaire

To aid in our diagnosis and treatment of your esthetic concerns and to prepare your Personalized Dental Plan, please take a moment to answer the following questions.

- Do you dislike the color of your teeth? Yes No
- Have you whitened your teeth? If so, How ______________________________ Yes No
- Do you have spaces between your teeth that bother you? Yes No
- Do you have chips or uneven edges on your teeth? Yes No
- Do you feel your teeth are too short or too long? Yes No
- Do you have dark fillings that show when you smile? Yes No
- Do your gums show too much when you smile? Yes No
- Are your teeth crowded or crooked? Yes No
- Do you have existing crowns or dental work that you think is "ugly"? Yes No
- Are you self-conscious of your teeth and/or smile? Yes No
- Do you avoid smiling when you have your picture taken? Yes No
- Do you wish you had a new smile? Yes No
- Are you interested in knowing what your cosmetic options are? Yes No

TMJ Issues

Please rate the current degree of comfort or discomfort as: "1" no pain and "10" worst

- TMJ clicking ____
- TMJ locking/stiffness ____
- Inability to open mouth ____
- Mouth doesn't open straight ____
- Pain when eating/chewing ____
- Pain in jaw or jaw joint ____
- Unstable bite ____
- Headaches ____
- Face pain ____
- Neck pain ____
- Ear pain/stiffness ____
- Ringing in ears ____
- Difficulty swallowing ____
- Throat pain ____
- Other ____________________ ____
- Other____________________ ____

Printed Name ________________________

Signature ____Date ______________