Cosmetic Dentistry

Name: ______________________________ Date of Birth: ____________________

Social Security Number: ____

Address: ____

City: _________________ State: __________ Zip: ___________________________

Phone: Home: ______________ Cell: ________________ Work: ______________

E-mail address: ____

Smile Information

Please check the areas of interest and concern:

_____	Tooth Color	_____	TMJ	_____	Tooth Size
_____	Dark Lines on Crowns	_____	Chipped Teeth	_____	Missing Teeth
_____	Gummy Smile	_____	Crooked Teeth	_____	Big Teeth
_____	Small Teeth	_____	Uneven Teeth	_____	Gaps/Spaces

Other: ____

Are your teeth sensitive to sweets or temperature? ______________________________

Do you grind or clench your teeth? ____

Do you have TMJ? ____

Do you notice popping or clicking in your jaw? ___________________________________

Do your gums bleed or have pain? ____

Have you had orthodontic treatment in the past? ________________________________