MARK X. McCARTHY, D. M. D.
GENERAL DENTISTRY
PATIENT DENTAL HISTORY

NAME_____

Do you have any dental complaints?
NO_____ YES_____ (Please describe)_____
Is any part of your mouth sore to pressure or irritants (cold, sweets, etc.)?
NO_____ YES_____ (Please describe)_____
Does any part of your mouth hurt when clenched?
NO_____ YES_____ (Please describe) _____
Have you experienced any growths or sore spots in or around your mouth?
NO_____ YES_____ (Please describe) _____
Have you ever had a local anesthetic (routine dental injection)?
NO_____ YES_____
Have you ever had any reaction or allergic symptoms to injections?
NO_____ YES_____ (Please describe) _____
Have you had any extractions?
NO_____ YES_____ (Any prolonged bleeding following extractions?) Please describe_____
Do your gums bleed?
NO_____YES_____
Have you ever been told you have pyorrhea, gingivitis or periodontitis?
NO_____YES_____
Have you had treatments for gum problems in the past?
NO_____YES_____
Have you ever had instructions on how to brush and floss your teeth?
NO_____YES_____
Do you have pain in or near your ears?
NO_____YES_____
Do you have frequent headaches?
NO_____YES_____ How often? _____
Have you ever had orthodontics (braces or retainers)?
NO_____YES_____
Have you ever had treatment for "TMJ" problems? (Including temporalmandibular joint dysfunction, myofacial pain or occlusal/bite problems)
NO_____YES_____
Are you satisfied with your past dentistry?
NO_____YES_____ Comments_____
(Optional) Would you like to share the reason you left your previous dentist?
NO_____YES_____ Comments_____
Has the fear of discomfort kept you from regular dental visits?
NO_____YES_____
When was your last visit to a dentist? _____
When was your last full mouth x-ray taken?_____
Additional comments: _____
_____
_____

Patient's signature_____Date_____ Over, please

Your Smile Evaluation

		Yes	No
1. Are you pleased and confident with the way your teeth look when you smile?		O	O
2. Do you have some unwanted spaces or gaps between your teeth?		O	O
3. Is there a chip or crack that you would like to have repaired?		O	O
4. Are you concerned about one or perhaps more than one tooth that is discolored?		O	O
5. Maybe you have some unattractive discolored metal or plastic fillings? (These can be either anterior/front or posterior/back teeth)		O	O
6. Do you have teeth that are slightly out of line, overlapping, or protruding?		O	O
7. Are your teeth shifting (spaces opening or closing)?		O	O
8. How are your gums?			
Are they red or swollen?		O	O
Have they receded from the top of your teeth?		O	O
9. Do you have some missing teeth that should be replaced?		O	O
10. Could your smile be improved if your teeth were	Whiter	O	O
	Longer	O	O
	Shorter	O	O
	Wider	O	O
	Narrower	O	O

11. Is there anything else you would like to discuss with Dr. McCarthy about your smile design or dental health?

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The answers to these questions will help you and Dr. McCarthy decide if cosmetic-restorative dentistry may improve your smile. The conservative nature of bonded porcelain restorations and their esthetic quality give you something to smile about!