DESIGNING SMILES TRACKER:

Name: _____ DOB:_____
Date Appt Made: ____/_____/_____ Team Member (initial):_____
Last Dental Hygiene Visit: ___/_____/_____ Last FMX/PAN:____/_____/_____
Referral Source:_____
Emailed NP info: Y / N ____/____/____ Follow up Phone Call: Y / N ____/____/____

Daily Home Care Routine: Circle All that apply

Electric Toothbrush ___ x day	Floss ___x day	Fluoride rinse
Manual Toothbrush ___ x day	Prescription toothpaste	Xylitol mints
Proxabrush	Waterpik	Fluoride trays
Saliva Substitute	Other: _____	

Are any of your teeth sensitive to: Hot Cold Sweets Biting Chewing
(Circle all that apply)

Have you ever had:	Orthodontic (braces) treatment?	Y	N
	Oral Surgery	Y	N
	Sleep Apnea treatment?	Y	N
	Injury to the mouth or head?	Y	N
	Describe_____		
Do You have:	Difficulty chewing on either side of your mouth?	Y	N
	Headaches, neck aches or shoulder aches?	Y	N
	Tired jaws, especially in the morning ?	Y	N
	An occlusal guard or mouth guard?	Y	N
Would you like to discuss levels of comfort that we offer?			
	Nitrous (laughing) gas	Y	N
	Premedication	Y	N
	Oral Relaxation	Y	N

Have you ever had an unpleasant dental experience? Y N
Please describe:_____
Are there any changes you would like to make in the appearance of your smile? Y N
Would you like to discuss the appearance of your teeth, gums, smile? Y N

Did any previous dentist recommend dental treatment that was never performed? Y N
Please describe:_____

CC:
CCH:

DO:

PP:

O:

Brief: