Dental Designs by Holst & Associates
401 East Robinson
Knoxville, IA 50138
(641) 828-8778

DENTAL DESIGNS
BY HOLST & ASSOCIATES

DENTAL HISTORY | SMILE EVALUATION

Date _____ Patient Name _____

DENTAL INFORMATION

1. Please state briefly the reason for your visit? _____
2. How long since your last dental visit? _____
3. ❒Yes ❒No Do your gums bleed, feel tender or irritated? _____
4. ❒Yes ❒No Are your teeth sensitive to hot, cold or sweets? _____
5. ❒Yes ❒No Are any teeth loose? _____
6. ❒Yes ❒No Do you grind, clench or grit your teeth? _____
7. ❒Yes ❒No Does your jaw ever click or cause pain on opening or closing? _____
8. ❒Yes ❒No Did you ever wear braces? _____
9. ❒Yes ❒No Have you ever worn any dental appliances? _____
10. ❒Yes ❒No Have you ever had gum treatments? _____
11. ❒Yes ❒No Do you wear dentures or plates? _____
12. ❒Yes ❒No Do you floss your teeth? _____
13. ❒Yes ❒No Have you ever had any unpleasant dental experiences or anything about dentistry you strongly dislike?

_____

SMILE EVALUATION

14. ❒Yes ❒No Do you like the way your teeth look? Why? _____
15. ❒Yes ❒No Are you happy with the color of your teeth? Why? _____
16. ❒Yes ❒No Would you like for your teeth to be whiter? Explain _____
17. ❒Yes ❒No Would you like for your teeth to be straighter? Explain _____
18. ❒Yes ❒No Do you have spaces between your teeth that you want closed? Explain _____

_____

19. ❒Yes ❒No Do you like the shape of your teeth? Explain _____
20. ❒Yes ❒No Do you have missing teeth that you would like to replace? Explain _____

_____

21. ❒Yes ❒No Do you have old silver fillings that you would like to replace with tooth-colored fillings? Explain _____

_____

22. ❒Yes ❒No Would you like to know more about any of our products or services? Explain _____

_____

23. If you could change anything about your smile, what would you change? _____

_____

_____