S C H M I D T

FAMILY & COSMETIC DENTISTRY

4963 MACKINAW RD., SAGINAW, MI 48603
PAUL M. SCHMIDT, D.D.S., P.C.

Patient Name: _____ Date: _____

Smile Checklist

Y◯	N◯	Are you happy with your smile?
Y◯	N◯	Do you cover your mouth when you smile?
Y◯	N◯	Do you wish your teeth were straighter?
Y◯	N◯	Do you wish your teeth were whiter?
Y◯	N◯	Do you brush your teeth daily? How many times?
Y◯	N◯	Do you floss daily?
Y◯	N◯	Do you use any mouth rinses? If so, what kind?

What would you change about your smile if you could? _____

Facial Pain History

Y◯	N◯	Do you have pain in face, neck or shoulders? (Please also circle the appropriate area)
Y◯	N◯	Do you have recurring tooth pain or sensitivity?
Y◯	N◯	Do you have ringing, fullness, or pain in your ears?
Y◯	N◯	Do you have difficulty opening your mouth or does your jaw get "stuck" or locked?
Y◯	N◯	Do your jaw joints create noises?
Y◯	N◯	Do you have difficulty or pain with chewing, talking, or yawning?
Y◯	N◯	Do you have arthritis?
Y◯	N◯	Have you had any previous treatment for your jaw joint problem? If so, when and by whom?
Y◯	N◯	Do you have difficulty swallowing?