New Jersey Dental Arts
Dr. Kaivon Rahaghi

326 Broad Street
Bloomfield, NJ 07003
Phone: (973) 743-7575
Fax: (973) 743-6096

T.M.D Evaluation

Patient's Name ______________________________ Date __________

1) Do you have difficulty or pain opening your mouth, chewing or yawning? YES NO
   Explain:

2) Does your jaw get "stuck", "locked" or "go out"? YES NO
   Explain:

3) Are you aware of noises when using your jaws? YES NO
   Explain:

4) Do your jaws regularly feel stiff, tight or tired? YES NO
   Explain:

5) Do you have pain in or about the ears, temples or cheeks? YES NO
   Explain:

6) Do you get frequent headaches and/or neck aches? YES NO
   Explain:

7) Have you had a recent injury to your head, neck or jaw? YES NO
   Explain:

8) Have you been aware of any recent changes in your bite? YES NO
   Explain:

9) Have you previously been treated for a jaw problem? If so, when and how? YES NO
   Explain:

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Smile Evaluation

Patient's Name ______________________________ Date __________

1) Do you like the appearance of your smile? YES NO
Explain:

2) Are your teeth all straight? YES NO
Explain:

3) Do you have spaces that you don't like? YES NO
Explain:

4) Do you like the color of your teeth? YES NO
Explain:

5) Are you interested in bleaching (whitening) your teeth? YES NO
Explain:

6) Do you like the shape of your teeth? YES NO
Explain:

7) Are there old fillings or dental work that you don't like looking at? YES NO
Explain:

8) What would you like to change the most in the appearance of your teeth? YES NO
Explain: