Welborne and White
EXCELLENCE IN DENTISTRY

Dental History

Patient Name _____ Medical Alert _____

Welcome to our Office!
Please complete both sides of this medical/ dental history form.
All information is completely confidential.

What is the main reason for your visit today? _____ Previous Dentist's Name _____

_____ Address _____

What is the date of your last dental visit? _____ State _____ Zip _____

What was done at your last dental visit? _____ Telephone _____

_____

SMILE EVALUATION

1. Do you like the way your teeth look? Yes ☐ No ☐

Explain _____

2. Are you happy with the color of your teeth? Yes ☐ No ☐

Explain _____

3. Would you like for your teeth to be whiter? Yes ☐ No ☐

Explain _____

4. Would you like for your teeth to be straighter? Yes ☐ No ☐

Explain _____

5. Do you have spaces between your teeth that you would like closed? Yes ☐ No ☐

If so, where? _____

6. Would you like your teeth to be longer? Yes ☐ No ☐

If so, Upper _____ Lower _____ Both? _____

7. Do you like the shape of your teeth? Yes ☐ No ☐

Explain _____

8. Do you have missing teeth that you would like to replace? Yes ☐ No ☐

Explain _____

9. Do you have old silver fillings that you would like to replace with tooth-colored fillings? Yes ☐ No ☐

Explain _____

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

_____