

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?

\_\_\_\_\_