annette williamson dds & associates
SMILES ON BROADWAY

DENTAL HISTORY

Patient's name _____ Today's date _____

Patient's date of birth _____ Date of last dental visit _____

Previous dentist's name _____ Previous dentist's phone _____

Reason for the visit today _____

Have you experienced any of the following problems? Please mark those that apply.

Bad breath		Crooked teeth		Loose teeth		Tooth pain	
Bad taste		Discolored teeth		Lumps/bumps in mouth		Wear dentures/partials	
Bleeding gums		Food between teeth		Sensitivity when biting		Wear a mouth guard	
Broken fillings		Grinding or clenching		Sensitivity to heat		Trauma to head to neck	
Burning sensation - mouth		Gum disease		Sensitivity to cold		Smoke or chew tobacco	
Chipped teeth		Jaw pops or locks		Sores in mouth		Tobacco use	

Have you ever experienced an adverse reaction during, or in conjunction with, a dental procedure? ☐ Yes ☐ No

If yes, please explain _____

Have you had a bad dental experience in the past? ☐ Yes ☐ No

If yes, please explain _____

If you could make changes to your smile, which of the following would you like to change?

Close spaces or gaps		Make smile whiter		Make smile straighter		Reduce gums when I smile	
Remove silver/grey fillings		Remove stains		Replace old crowns		Reshape teeth	

Would you like to keep your teeth all your life? _____

Have you had: ☐ Orthodontic treatment ☐ Oral surgery ☐ Periodontal treatment ☐ Mouthguard ☐ Serious injury to the mouth, jaw or head

Other information about your dental health or previous treatment: _____

Signature _____ Date _____

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