WILLIAMSBURG SMILES
400 Elm Street, Williamsburg, IA, USA
(319) 668-1221

Dental History

Dental History

Patient First Name

Patient Middle Initial

Patient Last Name

Patient Birth Date

Reason for your scheduled appointment? You can choose more than one.

- ☐ Just a regular exam,
- ☐ Pain,
- ☐ Cleaning,
- ☐ Second Opinion,
- ☐ Cosmetic Consult,
- ☐ Other,

Previous Dentist

Why are you changing your dentist?

When was your last dental exam?

When did you have your last dental cleaning?

Personal History

How often do you brush?

- ○ Every time I eat,
- ○ Three times a day,
- ○ Twice a day,
- ○ Once a day,
- ○ Occasionally,
- ○ Sometimes,
- ○ Never,

How often do you floss?

- ◯ Every time I eat,
- ◯ Three times a day,
- ◯ Twice a day,
- ◯ Once a day,
- ◯ Occasionally,
- ◯ Sometimes,
- ◯ Never,

Does going to the dentist make you nervous?

- ◯ No,
- ◯ Yes, slightly,
- ◯ Yes, moderately,
- ◯ Yes, extremely,

Have you ever had a bad experience at the dentist? yes / no

Please add any details here

Have you ever had complications from past dental treatment? yes / no

Please add any details here

Have you ever had trouble getting numb or had any reactions to local anesthetic? yes / no

Please add any details here

Periodontal / Gum disease

Do your gums bleed sometimes or are they ever painful when brushing or flossing? yes / no

Please add any details here

Have you ever been treated for gum disease or been told you have lost bone around your teeth? yes / no

Please add any details here

Is there anyone with a history of gum / periodontal disease in your family? yes / no

Please add any details here

Have you ever experienced or been told by a previous dentist that you have gum recession, or can you see more of the roots of your teeth? yes / no

Please add any details here

Have you ever had any teeth become loose without an external injury, or do you have difficulty biting into harder fruits and vegetables? yes / no

Please add any details here

Dental Problems

Are you teeth sensitive to hot, cold, sweet foods or liquids? Do you avoid brushing a part of your mouth because of sensitive teeth? yes / no

Please add any details here

Do you feel that your mouth is too dry or had difficulty swallowing food? yes / no

Please add any details here

Do you frequently get food caught between any teeth? yes / no

Please add any details here

Are you aware of sores or irritated areas in the mouth? yes / no

Please add any details here

Do you grind your teeth? Have you been told by a partner or a previous dentist that you grind your teeth? yes / no

Please add any details here

Improvements

Is there something you would like to change about your smile?

- ☐ The color of my teeth,
- ☐ Close spaces or restore worn out / broken teeth,
- ☐ Change the shape of my teeth,
- ☐ Make my teeth straighter,
- ☐ Replace missing teeth,
- ☐ Nothing, I like my smile,
- ☐ Other,

I would be interested in learning more about the following topics

- ☐ Teeth whitening,
- ☐ Cosmetic evaluation,
- ☐ Replacement of missing teeth,
- ☐ Straight teeth,
- ☐ Sedation,
- ☐ White fillings,
- ☐ Home care,
- ☐ Breath control,
- ☐ Other,