Full Name ……………………………………………………………………………..

Date ……………………………......

CONFIDENTIAL PATIENT DENTAL HISTORY & SMILE EVALUATION

This form is to help us obtain information about your dental history and better understand your needs.

When did you last have dental treatment?

Do visits to the dentist worry you? If yes, why?

yes / no

How important are your teeth to you?

not at all / moderately / very

Are you used to seeing a dentist or dental hygienist for cleaning & oral hygiene instruction?

dentist / dental hygienist / none

Do you have local anaesthetics for dental treatment?

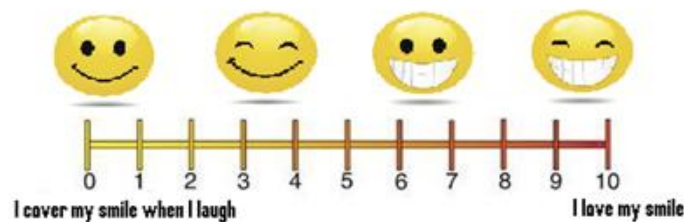
yes / no

Have you ever experienced any problems with them? If yes please detail…

Have you had orthodontic treatment in the past?

yes / no

If you had to give your smile a score out of 10, what would it be?



Is there anything about your teeth that bothers you?

yes / no

What changes would you make to improve your smile?

How would you like to pay for treatment?

cash | credit card | bespoke payment plan

Is there anything else that you would like to tell us?