Cosmetic Dentistry History Form

Patient Information

Full Name

Date of Birth

Phone

Email

Address

Dental History

Have you had any of the following? (Check all that apply)

- [ ] Veneers
- [ ] Crowns
- [ ] Teeth Whitening
- [ ] Braces/Orthodontics
- [ ] Implants
- [ ] Bonding

Other Cosmetic Treatments

What are your main cosmetic dental concerns?

What are your expectations?

Medical History

Physician Name

Physician Phone

Allergies

Current Medications

Medical Conditions

Additional Notes