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FAMILY & COSMETIC DENTISTRY

welcome. we're glad you're here!

To better serve you, please take just a couple of minutes to answer the following questions.
Thanks!

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold, or sweet)
If so, which teeth?
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath

Do you have, or have you had, any of the following?

- Dentures
- Partial dentures
- Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____

Last oral cancer screening _____

Last complete x-rays _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: () _____

What are the most important things to you about your smile and dental health?

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

- Yes No

Do you smoke or use chewing tobacco?

- Yes No

If yes, how much? And, for how long?

If you could change your smile, would you: (please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a 1 to 5 scale, 5 being the highest rating: (please circle the number that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health to be?

1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?