PATIENT INFORMATION

Thank you for providing us with important information that will help us serve you better.

(Circle one for each question)

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?

1 2 3 4 5 6 7 8 9 10

Check the ones that apply:

If I could change my smile I would make my teeth:

- Whiter ⇨
- Straighter ⇨
- Close Space ⇨
- Replace mercury fillings with tooth colored ⇨
- Repair chipped or cracked teeth ⇨
- Replace missing teeth ⇨
- Less gum showing ⇨
- Replace old crowns or caps that don't match ⇨

	Yes	No
1) Are you pleased and confident with the way your teeth look when you smile?	⇨	⇨
2) Do you think your dental health effects your overall health?	⇨	⇨
3) Do you smoke or use tobacco in any form?	⇨	⇨
4) Is it important to you to keep your teeth for your lifetime?	⇨	⇨
5) If there were a way to whiten your teeth would you be interested?	⇨	⇨

6) When was the last time you had an oral cancer exam? _____

7) What is the most important thing to you about your future smile and dental health?

_____

_____

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

_____

_____