

## 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?**