Name_____ Date_____

What are your current dental concerns?

What are your long-term dental goals?

How would you describe the level of dental treatment you have received in the past?

If you know, what was the condition of your biological parents' oral health?

Have you ever had a tooth crack or need a root canal?

__yes __no

Are you aware of any present or past periodontal (gum) issues

__yes __no

Would you like the doctor to explore treatment possibilities that will help keep your teeth and gums healthy throughout your life?

__yes __no

Ideally, how would you like your smile to look?

Are you dissatisfied with your overall smile?

__yes __no

Are there any old fillings, crowns or bridges that are not esthetic?

__yes __no

Would you like your teeth to be whiter?

__yes __no

Would you like your teeth to be straighter?

__yes __no

If possible, would you change the length, width or shape of your teeth?

__yes __no

If you could change anything else about the appearance of your teeth/smile what would it be?

Would you like the doctor to explore the possibilities of cosmetically enhancing your smile based on the concerns you have indicated above?

__yes __no

Are you uncomfortable when having dental treatment?

__yes __no

Would you like the doctor to discuss relaxation dentistry options with you?
__yes __no
What type of music do you enjoy listening to?
_____
Has anyone observed you choking or gasping during your sleep?
__yes__no
Do you clench or grind during the daytime or nighttime?
__yes__no
Is there anything else regarding your dental health, appearance or comfort that you would like to share or discuss with the doctor?
_____