

Cosmetic Dental Self-Evaluation

Please complete the following to help us decide how we can best help you.
 All information will be kept strictly confidential.

Name: _____ Consultation date: _____

Occupation: _____

1. How did you hear about our practice? Passing by Advertisement Where? _____
 Recommendation From whom? _____
 Other Please specify _____

2. What made you come to our practice? _____

3. Are you thinking about having a Smile Improvement for any special occasion?

Wedding Birthday Present Other _____ (please specify)

4. Have you ever had any cosmetic treatment before dental or otherwise? _____

5. Are you concerned about your Top Teeth Bottom Teeth Both

6. In order of importance which of the following concern you most about your teeth? (1= most important)

Whiteness _____ Straightness _____ Size _____ Length _____
 Shape _____ Gaps _____ Metal Fillings _____ Gums _____

7. On a scale of 1-10 (10 = good) how would you score your smile currently? _____

8. On a scale of 1-10 (10 = perfect) how perfect would you like your new smile to be? _____

9. Are you in any way anxious about having Dental Treatment? Yes No

If Yes, is it: Drills Smell Lack of Control Gagging Cost
 Needles Pain Lack of Information Other _____

10. Are you working to a particular budget? No Yes _____ (specify)

11. Have you visited any other dentist to discuss Cosmetic Dentistry? Yes No

12. Do you know anyone who has had cosmetic dental treatment? Yes No

If yes, did you think the results were: Very Good Average Poor

13. Is there anyone else who will be involved in your decision to have treatment? Yes No

14. What is the most important information or question you need answering at this visit?

15. Is there any particular time scale that you are working to? (Please detail) _____