



Today's date _____

Patient Number _____

1. Do you love the way your smile looks? Yes No

2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No

3. If you could change anything about your smile, it would be (check all that apply):

- Color of your teeth
- Too much or too little of teeth show when you smile
- Gaps between your teeth
- Size/Shape of your teeth
- Too much or too little of gum shows when you smile
- Alignment of your teeth
- Other: _____

4. Do you have (check all that apply):

- Sensitive or receding gums
- Worn/broken/chipped teeth
- Old or discolored fillings
- Missing teeth
- Old crowns that have dark edges at the top
- Other: _____

5. In your line of work or lifestyle, do you (check all that apply):

- Visit businesses or clients
- Travel
- Speak publicly
- Other: _____

6. If you had a smile makeover do you think you'd feel (check all that apply):

- More confident
- More optimistic
- Healthier
- Just OK
- No different
- Other: _____

7. Do you or someone in your family have issues with any of the following (check all that apply):

- Chronic bad breath
- Grinding teeth
- Snoring
- Other: _____

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

- Early morning
- Early afternoon
- No preference
- Late morning
- Late afternoon
- Other: _____

9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

10. What type(s) of music do you enjoy? (check all that apply)

- Easy Listening
- Classical
- Rock
- Hip-Hop/Rap
- Jazz
- Country
- R&B
- Other: _____

11. What are your favorite hobbies or activities?

12. Do you have children and grandchildren? If so, please list their names and ages.

13. Is there anything else that you want our office to know about you that will help us to serve you better?
