THE COSMETIC DENTAL CENTER & SPA

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NAME_____

DATE_____

In order that we may more fully understand & meet your needs, please complete the following:

1. Are you unhappy with the appearance of your teeth?	Yes	No
2. Are you dissatisfied with the appearance of your smile?	Yes	No
3. Do you have front teeth that show old, discolored fillings?	Yes	No
4. Do you have worn down teeth or chipped front teeth?	Yes	No
5. Do your front teeth appear short or wide to you?	Yes	No
6. Do your front teeth appear long or narrow to you?	Yes	No
7. Do you have spaces between your front teeth?	Yes	No
8. Do your gums bleed when you brush or floss your teeth?	Yes	No
9. Are you dissatisfied with the shape of your teeth?	Yes	No
10. Are you dissatisfied with the position of your teeth?	Yes	No
11. Do you dislike the color of your teeth?	Yes	No
12. Would you like to know more about techniques such as bonding or veneers?	Yes	No
13. Would you be interested in whitening your teeth?	Yes	No
14. Would you like to know more about replacing your old silver fillings with tooth colored restorations?	Yes	No
15. Would this be the first time you have had an examination with an intraoral camera?	Yes	No
16. When was your last professional dental cleaning?	_____	

If there was something that you could change about the appearance of your teeth and/or smile, what would it be?

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