Loving DENTISTRY

Personal Smile Evaluation

Patient Name: _____ Date: _____

Our mission is to provide you with the very best dental care. In order to provide you with customized care please take a moment to answer the following questions.

1. Is there something we can do to make your visits more comfortable? For example, what do you like least about dental visits? Or, please explain if you have previously had an uncomfortable dental visit.

The following questions are intended to gather personal information regarding your smile. This allows us to discuss information and treatment options based on <u>your</u> goals and wishes. If you are interested in making any changes to your smile, please take a moment to look at your teeth and gums and then answer the following questions.

2. Is there anything you would like to change about the appearance of your smile?

3. Are you interested in a brighter smile?

4. Do you have crooked or crowded teeth that concern you?

5. Do you have any spaces between your teeth that bother you?

6. Would you like to change the shape of your teeth? Please describe.

We would be happy to answer any questions you may have regarding your smile. Often it only takes a very minor change for people to love their smile. Our aim is to change lives, one smile at a time!