YOU AND YOUR SMILE

Name…….

Please tick any of the following problems that apply to you:

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates:

- Your last hygienist cleaning ____/____
- Your last oral cancer screening ____/____
- Your last complete X-rays ____/____

If you could whiten your teeth for an affordable cost, would you do it?

Do you smoke or use chewing tobacco?

How much?
How long for?

If I could change my smile, I would:

- Make my teeth brighter
- Make my teeth straighter
- Close spaces
- Replace black metal fillings with natural tooth-coloured fillings
- Repair chipped teeth
- Replace missing teeth
- Replace crowns that don't match
- Have a smile make-over

On a scale of 1 – 10, with 10 being the highest rating:

- How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

- Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is important about your future smile and dental health?

What is the most important thing about your dental visit today?

How did you hear about our dental practice?

Name, address and telephone number of previous dentist