

How Can We Help You?

JOSHUA B. BERNSTEIN

Name _____ Date _____



1. What is the reason for your visit? _____
2. What do you think is the current state of your mouth's health? _____
3. What are your treatment goals? (Check one):
 Pain relief/repairs only Average Care The best it can be
4. Tell us about your good dental experiences _____
and the bad ones _____
5. Why are you consulting with us rather than your previous dentist?

6. What about your smile would you like to improve (if anything)?

7. Do you have any friends or family that come to this office? Yes No
If yes, who? _____
8. What do you already know about our office and what are your expectations?

9. Has fear ever been an issue for you at the dentist? Yes No
If yes, please tell us more.

10. Has time ever been an issue for you in getting your dental work done? Yes No
11. Is the cost of dental treatment a concern for you? Yes No
If yes, would you like to discuss affordability options, such as financing? Yes No
12. We can look at your mouth from three different perspectives. Which of these would you like us to use for you? (Please check all that apply.)
 As a General Dentist As a Cosmetic Dentist As a Functional Dentist
13. At what point do you want us to initiate treatment? (Please check one.)
 When my tooth hurts/breaks When something is worsening When it's not ideal
14. What additional information would you like us to know?

15. How did you find out about our office? (Please check all that apply.)
 Personal Referral from _____
 Postcard Newspaper T.V. Commercial Internet Other
If you found us on the internet, what search words did you use? _____

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