

How Can We Help You?

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

Other (please specify) _____

4. Please tell us about your good dental experiences _____

5. Please tell us about your bad dental experiences _____

6. Why are you consulting with us rather than your previous dentist? _____

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

8. Do you have any friends or family that come to this office? Yes No

If yes, who? _____

9. What do you already know about our office and what are your expectations? _____

10. Has fear ever been an issue for you at the dentist? Yes No

If yes, please tell us more _____

11. Has time ever been an issue for you in getting your dental work done? Yes No
If yes, please explain _____

12. 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

13. We can look at your mouth from 3 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

14. 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
- Other _____

15. What additional information would you like us to know? _____

16. 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? _____