

DENTAL HEALTH AND APPEARANCE QUESTIONNAIRE

Reason for visit: _____

Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first?

If we were sitting here together a year from now, what needs to happen for you to consider our office an excellent choice for you? Examples might be: Being pain free, in great dental health, having whiter teeth, no silver fillings, cost, etc.

What things have you had happen to you at a previous dental office that you really liked? _____

What things have you had happen to you at a previous dental office that you really disliked? _____

If you could whiten your teeth for a cost most anyone could afford, would you be interested? YES NO

Please rate your smile from 1 to 10 (1= I hate my smile, 10=awesome) _____

If you had a magic wand, what, if anything, would you change about your smile?

Do you or has anyone ever told you that you snore? YES NO

Have you ever had a sleep test? YES NO

Do you currently have a CPAP? YES NO

If yes, do you wear it regularly? YES NO