

Today's date _____

Patient Number _____

- 1. Do you love the way your smile looks? Yes No
- 2. Do you feel comfortable showing your teeth when you laugh or smile? Yes No
- 3. If you could change anything about your smile, it would be (check all that apply):
 - Color of your teeth
 - Too much or too little of teeth show when you smile
 - Gaps between your teeth
 - Size/Shape of your teeth
 - Too much or too little of gum shows when you smile
 - Alignment of your teeth
 - Other: _____
- 4. Do you have (check all that apply):
 - Sensitive or receding gums
 - Worn/broken/chipped teeth
 - Old or discolored fillings
 - Missing teeth
 - Old crowns that have dark edges at the top
 - Other: _____
- 5. In your line of work or lifestyle, do you (check all that apply):
 - Visit businesses or clients
 - Travel
 - Speak publicly
 - Other: _____
- 6. If you had a smile makeover do you think you'd feel (check all that apply):
 - More confident
 - More optimistic
 - Healthier
 - Just OK
 - No different
 - Other: _____
- 7. Do you or someone in your family have issues with any of the following (check all that apply):
 - Chronic bad breath
 - Grinding teeth
 - Snoring
 - Other: _____

We'd like to know more about you so we can better serve you!

- 8. Do you prefer appointments in the (check all that apply):
 - Early morning
 - Early afternoon
 - No preference
 - Late morning
 - Late afternoon
 - Other: _____
- 9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)

- 10. What type(s) of music do you enjoy? (check all that apply)
 - Easy Listening
 - Classical
 - Rock
 - Hip-Hop/Rap
 - Jazz
 - Country
 - R&B
 - Other: _____
- 11. What are your favorite hobbies or activities?

- 12. Do you have children and grandchildren? If so, please list their names and ages.

- 13. Is there anything else that you want our office to know about you that will help us to serve you better?

