YOUR SMILE

•Is there anything about your smile that you would like to change?

☐ Make my teeth whiter

☐ Make my teeth straighter

☐ Replace silver fillings with tooth colored fillings

☐ Replace missing teeth

☐ Replace old crowns

☐ Close spaces between teeth

☐ Repair broken, chipped, or worn teeth

☐ Have a smile makeover

Please rate the following from 1 to 5 (5 being the highest)

•How important is your dental health to you?

☐1 ☐2 ☐3 ☐4 ☐5

•How would you rate your current dental health?

☐1 ☐2 ☐3 ☐4 ☐5

•What are your long term dental goals? ____

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•How can we help you meet your goals? ____

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