

Getting to Know You Better

Name: _____

Date: _____

Do you feel your overall oral health is? (Circle one)

Excellent

Good

Fair

Poor

Do your gums bleed when you brush?

Yes

No

Is there any area in your mouth that is hurting you now?

Yes

No

If yes where? _____

Does dentistry make you nervous?

Yes

No

If you could change anything about your smile, what would it be? (Circle all that apply)

Straighter Whiter

Space

I wouldn't change a thing

Is there anything you would like us to take care of today for you?

Yes

No

If yes what? _____