PAST DENTAL HISTORY

- Do you feel nervous about dental treatment? Yes No
- What can we do to alleviate your nervousness?

_____

_____

- Have you ever had a bad experience in a dental office? Yes No
- What can we do to make this experience better for you?

_____

_____

- Do you have sensitive teeth? Yes No
- Does food trap between your teeth? Yes No
- Do you think you have active decay or gum disease? Yes No

SMILE EVALUATION

1. Are you dissatisfied with the appearance of your smile? Yes No
2. Do you have spaces or gaps between your teeth? Yes No
3. Do you have old fillings or dental work which you perceive to be un attractive? Yes No
4. Are your teeth (please check the following that apply):

   ____ Chipped ____ Protruding ____ Crowded ____ Misshapen
5. If you could change one thing about your smile, what would it be?

   _____

   _____
6. If we could offer you a simple and inexpensive way to whiten your teeth, would you be interested?

   Yes No
7. How would you like your teeth to look in 15 years?

   _____

   _____