NEW PATIENT SURVEY

How can we help you?

_____ Improve the appearance of teeth / smile _____ Overall dental health and prevention of tooth loss
_____ Toothache / TMJ Pain

How have your dental experiences been in the past?

_____ excellent _____ mediocre _____ frightening/painful

If frightening, what causes this? _____
What could we do to help you with this? _____

Why did you leave the dental office that treated you previously? _____
Please explain how we can improve / resolve this problem in our office, if possible.
_____

If applicable, why have you put off seeking dental health for so long?

_____ money _____ time _____ procrastination _____ pain/fear

Have you had regular checkups and cleanings over the past several years? _____
When was your last cleaning? _____

Do your gums ever bleed when you brush? _____ How often do you brush? _____
Do you use an electric toothbrush? _____ Floss? _____ How often do you floss? _____
Do you think that your breath is as fresh as it could be? _____

How do you rate the importance of saving your teeth? _____

Have you lost any teeth? _____
If yes, has it ever been recommended to you that the tooth / teeth be replaced? _____

Do any of your family members wear dentures? _____
If yes, did they lose their teeth at an early age? _____

Has dentistry ever been presented to you that you chose not to complete? _____

Do you like your smile? _____
What are your long-term goals regarding your dental health? How would you like your teeth to look and feel?
_____

Subjective Sleep Evaluation: Do you snore?_____

Our goal is to provide you with the finest and most state of the art dentistry. In so doing, we hope to keep you as a patient for a life-time. What would help us accomplish this goal? _____
_____

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