



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 will improve/resolve this problem in our office, if possible.

If applicable, why have you neglected your 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? _____
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? _____

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?

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

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