Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

_____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient/friend ☐ Another Doctor

☐ Radio ad ☐ Magazine ad ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code