

HOW CAN WE HELP YOU?

Name Date

1. What is the reason for your visit?
2. What do you think is the current state of your mouth's health?
3. What are your treatment goals? Pain relief/Repairs only Average care The best it can be
4. Tell us about your dental experiences.

Good experiences:

Bad ones:
5. Why are you consulting with us rather than your previous dentist?
6. What about your smile would you like to improve (if anything)?
7. Do you have any friends or family that come t this office? Yes No
If yes, who?
8. What do you already know about our office and what are your expectations?
9. Has fear ever been an issue for you at the dentist? Yes No
If yes, tell us more
10. Has time ever been an issue for you getting your dental work done? Yes No
11. Is the cost of dental treatment a concern for you? Yes No
If yes, would you like to discuss affordability options, such as financing? Yes No
12. We can look at your mouth from three different perspectives. Which of these would you like us to use for you? (check all that apply) As a General Dentist As a Cosmetic Dentist As a Functional Dentist
13. At what point do you want us to initiate treatment (check one)
 When my tooth hurts/breaks When something is worsening When it's not ideal
14.
15. How did you find out about our office? (check all that apply)

Personal Referral from

Postcard Newspaper TV.

Internet What search keywords did you use?

Other