Dental Artistry
BY DR. CHOI

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 experieces.
   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 _____

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