Patient Name: Date:

Patient Evaluation

Are your teeth all in alignment (straight)?	❑ Yes ❑ No
Do you have any missing or chipped teeth?	❑ Yes ❑ No
Is your bite comfortable for chewing?	❑ Yes ❑ No
Do you have frequent headaches?	❑ Yes ❑ No
Do you have any old fillings or dental work that you do not like?	❑ Yes ❑ No

What would you like to change most in the appearance of your teeth? ________________

____

Are you nervous about dental treatment?	❑ Yes ❑ No
Is there anything about your mouth that concerns you?	❑ Yes ❑ No
What type of toothbrush do you use?	❑ Soft ❑ Medium ❑ Hard
Do you use dental floss or toothpicks? How often? ______________________	❑ Yes ❑ No
Do you have any swelling, sores, or blisters in your mouth?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you chew tobacco?	❑ Yes ❑ No
Do you feel that you have unpleasant breath at times?	❑ Yes ❑ No
Are you aware of the new techniques in dentistry?	❑ Yes ❑ No