Elite Smiles
Dental Evaluation

Age: _____ How did you hear about our office? _____

How long has it been since your last dental visit? ___ 6mos ___1-2 yrs ___3-5 yrs ___ 5+ yrs

What is your main concern today?
___Tooth Pain ___Sensitivity ___Broken/Cracked Tooth ___ Cavities/Decay ___Cosmetic Dentistry

___ Missing Teeth/Implant ___ Old Dentistry ___ Gum Disease ___ Cleaning ___ Orthodontics

___ Dentures ___ Whitening ___ Sedation Dentistry ___ Gum Recession

If the Doctor finds an issue that should be addressed immediately, are you interested in having work done today? _____ Yes ____ No

Do you have anxiety, fear, or bad experiences associated with the dentist office? __Yes __No
___ Low Anxiety/Fear ___ Moderate Anxiety/Fear ___ High Anxiety/Fear

Do you like the appearance of your smile and look of your teeth? ___Yes ___No
If NO, what would you most like to change about your teeth? _____

What is most important to you when seeking dental treatment?
____Quality of Service ____Technology ____ Comfort ____ Fear/Sedation ____ Cost

____ Conventional Office Hours ____ Friendliness of Staff ____ Cleanliness of Office

Are you aware of clenching/grinding your teeth? ___ Yes ____ No

Have you had orthodontic treatment (braces)? ___ Yes ___ No

Have you had your wisdom teeth extracted? ___ Yes ___ No

How many times a day do you brush? _____ How many times a week do you floss? _____

Have you ever had sedation dentistry? _____ Yes ____ No

Are you concerned about bad breath? ____ Yes ____ No

May we take necessary dental x-rays in order to provide you with an accurate diagnosis? __Yes __No

Is there anything else you would like us to know about you?

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