



Patient Preferences

Patient: _____

Date: _____

Briefly tell us how you feel about your teeth, your smile, and your dental expectations.

1. What are your expectations from this office? _____

2. Would you like to learn how you can have all of your teeth for the rest of your life? ___ Yes ___ No

3. If you are already missing some teeth, would you like to learn how you can avoid having full dentures? ___ Yes ___ No

4. Do you like your smile? ___ Yes ___ No

5. If the answer is NO, what don't you like and what changes would you like to see? _____

6. If you feel that your teeth have yellowed, or are not white enough, would you like to learn about tooth whitening? ___ Yes ___ No

7. Are you interested in an overall cosmetic dental evaluation? ___ Yes ___ No

8. If you are contemplating a dental cosmetic change, what is most important to you? _____

9. Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment? ___ Yes ___ No

10. Have all your past dental office experiences been positive? ___ Yes ___ No
if NO, please explain: _____

11. Is there anything in particular that you would like us to always do for you? ___ Yes ___ No
if YES, please explain: _____

12. Is there anything in particular that you would like us never to do? ___ Yes ___ No
if YES, please explain: - _____

13. Do you have any dental concerns not listed here that you would like to bring to our attention? ___ Yes ___ No
if Yes, please explain: _____

14. If our office needs to contact you, you prefer: Mail _____ Telephone _____ Text _____ Email _____
My email address is: _____