

# COSMETIC EVALUATION FORM

Welcome! So that we may provide you with the best possible care please complete the cosmetic evaluation form. All information is completely confidential.

Patient Name \_\_\_\_\_ Medical Alert \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Do you have any dental problems now? Yes No

If yes, please describe \_\_\_\_\_

Date of last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth x-ray \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? \_\_\_\_\_

Why was this treatment never performed? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

What other dental aids do you use? (Rotodent, Interplak, toothpick, etc.) \_\_\_\_\_

Noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesion? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught between any teeth? Yes No

If yes, where? \_\_\_\_\_

## Do You:

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Do you feel nervous about dental treatment? Yes No

Ever had an upsetting dental experience? Yes No

## Have you ever had:

Oral Surgery? Yes No Periodontal Treatment? Yes No

Your teeth ground or bite adjusted? Yes No

A bite plate or mouth guard? Yes No

Please **Circle** the following dental values **most important** to you and **Underline** the **least important**:

Esthetics      Comfort      Longevity      Function      Long-term cost effectiveness

Please **Circle** the **most important feature(s)** in your smile that you would like to change?

Color Shape      Alignment      Length Gaps      Gum Display      Nothing, I'm Happy      Other \_\_\_\_\_

**Would you like your smile analyzed?** Yes No

**If yes,** is there a spouse or significant other you want to include in our discussion? Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe \_\_\_\_\_