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 Yes No

(pencils, pipe, pins, nails, fingernails)

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__________________________________________________________