Your Name: _____ Date: _____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? _____

- In your opinion, what do you think the present state your oral health is? _____

_____

- What do you already know about our office and what are your expectations? _____

_____

- How healthy do you want us to get your mouth? (please circle)

The best it can be Average Don't really care

- Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal When something is worsening When my tooth hurts or breaks

- What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best Average Just patch it

- We have the ability to look at your mouth from three different perspectives. What combination of these would you like us to use for you? (please circle all that apply)

As a general dentist As a cosmetic dentist As a functional dentist

- How do you feel about the appearance of your face and smile? _____

_____

- What would it take for you to trust us to be your dentist? _____

_____

- Tell us about your good dental experiences. _____

- And the bad ones. _____

- Has fear ever been an issue for you in a dental office? _____

- What caused you to leave your last dental office? _____

- Has time ever been a factor in getting your dental work done? _____

- Has cost of dental treatment been a concern for you? _____

- What can we do to help you with this? _____

- Is there any additional information you would like us to know? _____