

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Evaluation

Are your teeth all in alignment (straight)?  Yes  No

Do you have any missing or chipped teeth?  Yes  No

Is your bite comfortable for chewing?  Yes  No

Do you have frequent headaches?  Yes  No

Do you have any old fillings or dental work that you do not like?  Yes  No

What would you like to change most in the appearance of your teeth? \_\_\_\_\_

Are you nervous about dental treatment?  Yes  No

Is there anything about your mouth that concerns you?  Yes  No

What type of toothbrush do you use?  Soft  Medium  Hard

Do you use dental floss or toothpicks?  
How often? \_\_\_\_\_  Yes  No

Do you have any swelling, sores, or blisters in your mouth?  Yes  No

Do you smoke?  Yes  No

Do you chew tobacco?  Yes  No

Do you feel that you have unpleasant breath at times?  Yes  No

Are you aware of the new techniques in dentistry?  Yes  No