Newbury Park
DENTAL ARTS

Name: _____ **Date:** _____

DENTAL COSMETIC QUESTIONNAIRE

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions, circle any words that may apply, and provide us with any additional information.

How do you rate your smile on a scale of 1-10 with 10 being the best smile? 4

When I see a picture of myself, the first thing I notice about my smile is:

Do you like the color of your teeth? (dark, dull, stained, mismatched?)

Do you feel that your teeth are too small or too short?

Do you feel that your teeth are too large or too long?

Are your teeth crooked or out of line?

Are there spaces between your teeth you don't like?

Do you show a lot of gum tissue when you smile?

Are your gums irregularly shaped (higher or lower on some teeth)?

Are the biting edges of your teeth uneven, worn down, or chipped?

Do your teeth slant one way or another?

Is the midline of your upper two front teeth centered with your nose?

Have your gums receded?

Are there any dental fillings or crowns that don't match your teeth or look ugly?

Are any of your teeth missing?

Do you feel that your smile is too narrow?

Do you feel that you don't show enough teeth when you smile?

Is there anything else about your smile or teeth that you don't like, would like to change, or would like us to know about?

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Our office is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability . . . thank you!

What is the main purpose of your first visit and what would you like to get accomplished?

Briefly mention any positive or negative aspects of your previous dental visits

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

TREATMENT RECOMMENDATIONS OR TREATMENT OPTIONS?

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you, please rate on the following scale from 10 to 1.

1. How (dental) healthy would you like to be?

10	9	8	7	6	5	4	3	2	1

10 (healthiest) *1 (not a concern at this time)*

2. Almost all dental problems are predictable and preventable. In order to not overwhelm you with excess details, how preventative (or proactive) would you like to be regarding dental disease?

10	9	8	7	6	5	4	3	2	1

10 ("nip in the bud early") *1 (wait until it hurts)*

3. How important are dental cosmetics to you?

10	9	8	7	6	5	4	3	2	1

10 (very important) *1 (not important)*

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.

4. How important is facial cosmetics to you?

10	9	8	7	6	5	4	3	2	1

10 (healthiest) *1 (not a concern at this time)*

5. Anything else you would like to mention ?