

Signature _____

Date

Relationship to patient _____ If patient is LESS THAN 18 YEARS OLD, parent or legal guardian MUST sign above

DENTAL HEALTH and APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your *primary* concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

Is so, explain: _____

What, if anything, has happened in previous experiences at the dentist, that was reason not to return? _____

Do you have missing teeth? _____ If yes, have you had them replaced? _____

If you *have* had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____ What type of brush do you use? SOFT MED HARD

Do you avoid brushing any part of your mouth because of pain? Yes No . If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings? Yes No

Do you chew on only one side of your mouth? Yes No If yes, explain: _____

Do your gums feel tender or swollen? Yes No Do you usually have many cavities? ... Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No Do your jaws ever feel tired? Yes No

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – *until* it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth. Please check **all** that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and *last* for a long time
- Spreading payments out over time may help me to achieve the excellent results I desire
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire
- I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now
- Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please *rate* your smile from 1 to 10 (1= I hate my smile, 10= awesome) _____

Would you like to have whiter teeth? Yes No

If you had a *magic wand* what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any *special* occasions coming up? _____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World-Class Smile, *often overnight*...

Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes No . If yes, please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At the Center for Cosmetic Dentistry, though **our focus is on appearance-related dentistry**, our on-site team delivers 99% of your routine dental needs as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm regards,
Tom Kratzenberg