



Dental Care Update

Please take a few moments to answer the following questions. Thank you.

Name: _____ Date: _____

Please Circle

Are you presently having a dental problem? Yes No

If so, Please explain: _____

Do you use tobacco products of any kind? Yes No

Do your gums bleed? Yes No

Do you have bad breath or has someone told you that you do? Yes No

Are you happy with the appearance of your smile? Yes No

Would you like some information about teeth whitening? Yes No

Would you like information about straightening your teeth without braces and without people noticing? Yes No

Would you like information on Cosmetic Dentistry procedures such as bonding, porcelian veneers, crowns or bridges? Yes No

If you are missing teeth, would you like to learn about the longest lasting most natural tooth replacement option? Yes No

Do you or someone you know snore and/or not get a good night's rest? Yes No

Whom can we thank for referring you to our office?
