

New Client Survey

Name _____ Date _____

Please complete the following questions

- | | Yes | No |
|---|-------|-------|
| 1. I would like a complete & thorough dental examination | _____ | _____ |
| 2. I would like to be informed of all the conditions in my mouth | _____ | _____ |
| 3. I am interested in finding out about the most permanent and cost effective treatment available | _____ | _____ |
| 4. I am happy with the shape and color of my teeth | _____ | _____ |

On a scale of 1 to 10 (with 10 being the highest quality rating) how would you rate the following:

How would you rate your overall oral health condition at present _____
Where would you like your overall oral health condition to be _____

- a. What are your primary concerns today?
- b. When was the last time you visited the dentist and for what reason?
- c. Have you ever had any of the following diagnostic evaluations:
- | | | | |
|--------------------------------|-----|------------------------|-----|
| An intra-oral camera exam | Y N | A panoramic x-ray | Y N |
| Digital x-rays | Y N | Laser cavity detection | Y N |
| A bite analysis | Y N | Oral Cancer Screening | Y N |
| Thorough periodontal screening | Y N | Caries risk assessment | Y N |
- d. Have you ever had any of the following:
- | | | | |
|----------------------|-----|------------------------|-----|
| Wisdom tooth removal | Y N | Orthodontics | Y N |
| Root Canal treatment | Y N | Crowns/Bridges | Y N |
| Mercury fillings | Y N | Tooth-colored fillings | Y N |
- e. Have your parents ever experienced tooth loss?
- f. Are you concerned about the condition or appearance of your teeth?
- g. Do you plan on keeping your teeth for the rest of your life?