CROSSROADS DENTAL

Family and Cosmetic Dentistry

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PERSONAL SMILE EVALUATION

How did you find out about our office?

- ☐ Advertisement
  Type: _____
- ☐ Friends or Family
  Name: _____
- ☐ Walk in
- ☐ Insurance

On a scale of 1 to 10 with 10 being the highest rating:

* How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

* Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

* Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health affects your overall health?	Yes	No
Do you think it is important to have your teeth cleaned at least every six months?	Yes	No
Is the brightness of your teeth important to you?	Yes	No
If I could change my smile I would make my teeth:		
Whiter	Yes	No
Straighter	Yes	No
Close Space	Yes	No
Replace black mercury fillings with tooth colored restorations	Yes	No
Repair chipped teeth	Yes	No
Replace missing teeth	Yes	No
Less gum showing	Yes	No
Replace old crowns or caps that don't match	Yes	No
Do you prefer to save your teeth?	Yes	No

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____