

### Cosmetic Information

Is there anything about your smile that you do not like? \_\_\_\_\_

Are you interested in knowing the options available for a more beautiful smile? \_\_\_\_\_

Do you like the appearance of your teeth? \_\_\_\_\_

Are all of your teeth in alignment (straight)? \_\_\_\_\_

Do you have any missing teeth? \_\_\_\_\_ Are any chipped? \_\_\_\_\_

Is your bite comfortable when chewing, biting? \_\_\_\_\_

Do you have frequent headaches? \_\_\_\_\_

Do you have any old fillings or dental treatment that you are unhappy with? \_\_\_\_\_

What would you like to change the most about the appearance of your teeth? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you would like us to know? \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another Doctor  Dental Office  
 Internet  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code