Dr. Zwier

How is your smile?

Name: _____

Phone: _____ Email: _____

How did you hear about our office? _____

Please take a moment to evaluate how you feel about your smile.

If you could whiten your teeth for a cost anyone could afford, would you do it?	YES | NO
Do you have spaces between your teeth, or missing teeth that bother you?	YES | NO
Do you have chips or uneven edges on your teeth?	YES | NO
Do you feel that your teeth are too long or too short?	YES | NO
Do you have dark fillings that show when you smile?	YES | NO
Do your gums show when you smile?	YES | NO
Are your teeth crowded or crooked?	YES | NO
Do you have existing crowns that you consider “ugly”?	YES | NO
Are you self-conscious of your smile?	YES | NO
Do you avoid smiling when you have your picture taken?	YES | NO
Would you like to hear the options available to improve your existing smile?	YES | NO

What, if any, concerns do you have?

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?

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

Why did you leave your previous dentist?