

Patient Pre-Appointment Questionnaire

Date: _____

Patient Name: _____

We look forward to seeing you for your appointment. Please take a moment to fill out the questions below so that we can better serve your dental needs.

1. Do you like your smile?

yes no

2. Are you interested in whiter teeth?

yes no

3. Do you want straighter teeth?

yes no

4. If there is one thing you could change about your smile, what would it be?

..... ☺ Thank you for taking the time to fill out this questionnaire ☺

OFFICE USE ONLY

CLINICAL REVIEWED _____

DOCTOR REVIEWED _____