

Cosmetic Self-evaluation

Please complete this form to help us decide how we can best help you.

All information will be kept strictly confidential.

Name:
Date:
Occupation:

Are you thinking about having a Smile improvement for any special occasion?
Wedding Birthday Present Other (please specify)
If so, when is this occasion?

Have you ever had any cosmetic treatment before, dental or otherwise?
(please specify)

Are you concerned about your: top teeth bottom teeth both

In order of importance, which of the following concern you most about your teeth? (1=most important)

Whiteness	Straightness	Size	Length
Shape	Gaps	Metal fillings	Gums
Other (please specify)			

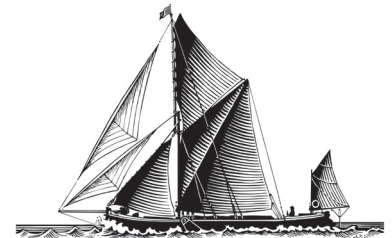
On a scale of 1-10 (10=good) how would you score your smile currently?

On a scale of 1-10 (10=perfect) how perfect would you like your new smile to be?

Are you in any way anxious about having dental treatment? Yes No
If yes, is it:
drills cost lack of control
needles pain lack of information other

Is there anyone else who will be involved in your decision to have treatment?
Yes No (please specify)

What is the most important information or question you need answering at your next visit?



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Important

- please use the back of this form if you want to give us more information
- the more information you give us, the easier it will be for us to understand exactly what you want from your new smile
- if someone else is involved in deciding how your smile should look, please ask them to come with you to your next visit

