PATIENT GOALS

Date:	Patient Name:	Birth Date:

PATIENT GOALS	
What is your goal for dental treatment today?	
Are you in discomfort today? ☐ Yes ☐ No (If no, please explain below)	
Are you pleased with the appearance of your teeth? ☐ Yes ☐ No (If no, please explain below)	
Do you like your smile? ☐ Yes ☐ No	Do you wish your teeth were whiter? ☐ Yes ☐ No
Do you have old fillings or dental work that you don't like the look of? ☐ Yes ☐ No	
Have you lost any teeth or have any teeth been removed? ☐ Yes ☐ No	
Have they been replaced? ☐ Yes ☐ No (If yes, how?)	
Are you happy with the replacement? ☐ Yes ☐ No	
How can we help you improve your teeth and smile?	
Have you ever had a bad dental experience in a dental office? ☐ Yes ☐ No (If yes, please explain below)	
Does dental treatment make you nervous? ☐ Yes ☐ No	
Have you been pleased with your previous dental care? ☐ Yes ☐ No	

Explanation or other details: