



### COMFORT MENU

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

- Patients find that if they take an analgesic prior to treatment it helps later in the day.  
Which would you prefer? Tylenol Advil Other \_\_\_\_\_

- We provide various levels of sedation to ease your mind.  
Would you benefit from a sedative?.....Yes  No

If yes, we provide:  Nitrous Oxide (laughing gas)  
 Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from the appointment.  
 Intravenous sedation (IV) administered by a board certified anesthesiologist. With IV sedation, you will need someone to drive you to and pick you up from the appointment.

- Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

- Blankets help keep you warm and relaxed through your visit.  
Would you like a blanket?.....Yes  No

- Pillows provide an extra measure of comfort if you have a sore back or neck.  
Would you like a pillow?.....Yes  No

- Is there anything else we can do for you to make your visit comfortable?

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## DENTAL HEALTH AND APPEARANCE

Reason for visit: \_\_\_\_\_ Approximate date of last dental visit: \_\_\_\_\_

What is your primary concern that you would like us to address first? \_\_\_\_\_

When would you like us to start treatment? \_\_\_\_\_

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?.....Yes  No

If so, explain: \_\_\_\_\_

What, if anything, has happened in previous experiences at the dentist that was reason not to return? \_\_\_\_\_

Do you have missing teeth?\_\_\_\_\_ If yes, have you had them replaced?\_\_\_\_\_

If you have had missing teeth replaced, are you happy with the results? \_\_\_\_\_

If not, would you like to learn about your options to replace them? \_\_\_\_\_

Do you ever feel (or have you ever been told) that you don't have fresh breath? \_\_\_\_\_

How often do you brush your teeth?\_\_\_\_\_ How often do you floss?\_\_\_\_\_ What type of brush do you use? Manual  Powered

Do you avoid brushing any part of your mouth because of pain? Yes  No  If yes, what part? \_\_\_\_\_

Which foods cause you twinges of pain: hot  cold  sweet  sour  none  Do you lose fillings or break fillings?.....Yes  No

Do you chew on only one side of your mouth?.....Yes  No  If yes, explain: \_\_\_\_\_

Do your gums feel tender or swollen?.....Yes  No  Do you usually have many cavities?.....Yes  No

Do you clench or grind your jaws while sleeping or during the day?.....Yes  No  Do your jaws ever feel tired?.....Yes  No

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

## COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? \_\_\_\_\_ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)\_\_\_\_\_

Would you like to have whiter teeth?  Yes  No

If you had a magic wand, what, if anything, would you change about your smile?\_\_\_\_\_

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? \_\_\_\_\_

Do you have any special occasions coming up? \_\_\_\_\_

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight... Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes  No  If yes, please check off all that apply:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation   | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth            | <input type="checkbox"/> Lengthen            | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile        |
| <input type="checkbox"/> Close spaces between teeth      | <input type="checkbox"/> Shorten             | <input type="checkbox"/> Eliminate crowding    | <input type="checkbox"/> Repair uneven edges                |

Please add anything you feel is important: \_\_\_\_\_

At Better Image Dentistry, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

## YOUR DENTAL NEEDS

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern? \_\_\_\_\_

• What do you think is the present state of your oral health? \_\_\_\_\_  
\_\_\_\_\_

• What do you already know about our office and what are your expectations? \_\_\_\_\_  
\_\_\_\_\_

• How healthy do you want us to get your mouth? (please circle)

The best it can be      Average      Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal      When something is worsening      When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best      Average      Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

— As a general dentist    — As a cosmetic dentist    — As a functional dentist

• How do you feel about the appearance of your face and smile? \_\_\_\_\_  
\_\_\_\_\_

• What would it take for you to trust us to be your dentist? \_\_\_\_\_  
\_\_\_\_\_

• Tell us about your good dental experiences. \_\_\_\_\_

• And the bad ones. \_\_\_\_\_

• Has fear ever been an issue for you in a dental office? \_\_\_\_\_

• What caused you to leave your last dental office? \_\_\_\_\_

• Has time ever been a factor in getting your dental work done? \_\_\_\_\_

• Has cost of dental treatment been a concern for you? \_\_\_\_\_

• What can we do to help you with this? \_\_\_\_\_

• Is there any additional information you would like us to know? \_\_\_\_\_