NEW PATIENT PROFILE

Name: ______________________________

Date: ______________________________

1: How did you hear about our practice? ______________________________

2: How may we help you?

__________ Improve appearance of teeth/smile
__________ Overall dental health and prevention of tooth loss
__________ Toothache/pain

3: How have your dental experiences been in the past?

_______ Excellent _______ Mediocre _______ Frightening/Painful

If Frightening/Painful, what can we do to help you with this? ______________________________

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4: Have you had regular check-ups and cleanings over the last several years? ______________________________

5: Approximately when was your last cleaning? ______________________________

6: If applicable, why have you neglected your dental health for so long?
____ Money ____ Time ____ Procrastination ____ Pain/Fear

7: Do any of your family members wear dentures? ______________________________
If so, who? ______________________________

8: Do your gums bleed when you brush? __________________ Floss? __________________

9: How often do you brush? ______________________________

10: How often do you floss? ______________________________

11: Do you think your breath is as fresh as it can be? ______________________________

12: Do you like your smile? ______________________________

13: What would you change about your smile if you could? ______________________________