Alexander Family Dental

Smile and Oral Health Evaluation

Thank you in advance for taking the time to allow your new dental team the opportunity to get to know you better. Where applicable please rate your responses from 1-10 with 1 being a little and 10 being a lot.

Patient Name _____

1. What did you like about your previous dental experiences?
   Explain: _____
2. What did you not like about your previous dental experience or experiences?
   Explain: _____
3. Is there anything we can do to make your visit more comfortable? ☐Yes ☐No
   Explain: _____
4. Rate how anxious you are about dental treatment. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
5. Rate your overall oral health. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
6. Would you like optimal oral health care? ☐Yes ☐No
   Tell us more: _____
7. Rate the appearance of your smile. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
8. Rate the color of your teeth? 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
9. Rate your concern with mercury fillings. 1 2 3 4 5 6 7 8 9 10
   Tell us more: _____
10. Rate the straightness of your teeth. 1 2 3 4 5 6 7 8 9 10
    Tell us more: _____
11. Are you concerned with losing or missing teeth? ☐Yes ☐No
    Tell us more: _____
12. Is there anything we can do to enhance your smile and optimize your oral health? ☐Yes ☐No
    Tell us more: _____

PATIENT / GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

DR.'S SIGNATURE DATE