evaluation form

So we may better serve you, please take just a couple of minutes to answer the following questions. Thank you!

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DR. VALERIE
STAVRO
LASER + AESTHETIC
DENTISTRY

Please check any of the following problems that apply to you:

☐ Sensitivity (hot, cold, or sweet)
If so, which teeth?
☐ Headaches, earaches, neck pain
☐ Teeth or fillings breaking
☐ Grinding or clenching teeth
☐ Bleeding, swollen or irritated gums
☐ Loose, tipped, or shifting teeth
☐ Bad breath

Do you have, or have you had, any of the following?

☐ Dentures/Partial dentures
☐ Implants
☐ Periodontal (gum) treatments

Please share the following approximate dates:

Your last hygiene visit ______________________
Last oral cancer screening __________________
Last complete x-rays ______________________

Who was your previous dentist?
This information is used to request records with your consent

Name: ________________________________
City: ____________________Province: _____
Phone: ( ) ________________

What are the most important things to you about your smile and dental health?

____
____
____

If you could whiten your teeth, at a cost that anyone could afford, would you like to?

☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much? And, for how long?

____

If you could change your smile, would you:
(please check all that apply)

☐ Make your teeth whiter
☐ Make your teeth straighter
☐ Improve gum health
☐ Improve bad breath
☐ Close spaces between teeth
☐ Replace black metal fillings with tooth-colored restorations
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns that do not match
☐ Have a smile makeover

On a 1 to 5 scale, 5 being the highest rating:
(please circle the number that best applies)

How important is your dental health to you?
1 2 3 4 5

How would you rate your current dental health?
1 2 3 4 5

Where do you want your dental health to be?
1 2 3 4 5

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today?